

ONEN'TO:KON HEALING LODGE
IN-HOUSE APPLICATION PACKAGE



Return to: Onen'tó:kon Healing Lodge

Fax: (450) 479-1034

or

Email Intake Worker:

debbie.bonspille@ohloffice.org

or contact the Outreach Worker

Ashley Norton: 514-668-6399

380 St. Michel, KANEHSATAKE, QC J0N 1E0
Tel.: (450) 479-8353 email: info@onentokon.org
Website: www.onentokon.com



REFERRAL INFORMATION

Please See Intake Schedule on Page 21 of this document.

This section of the referral kit provides a brief description of our treatment program, includes an outline of our eligibility criteria, as a Substance Abuse Healing Lodge, and gives detailed information to referral workers concerning our admission procedures. Referral workers are invited to keep this part of the referral kit for information.

ONEN'TO:KON TREATMENT PROGRAM

Onen'to:kon Healing Lodge (OHL) is located in the Mohawk community of Kaneshatake. Onen'to:kon meaning "Under the Pines" is situated near Oka and Montreal, overlooking the Lake of Two Mountains.

Our (6) six week program is a **Trauma Focused – Culturally Based** program, which incorporates traditional practices of healing while working with individuals One-to-One. Our program's belief is that understanding the trauma that one has faced in his/her/their life and to reconnect with Native Culture along with individual counselling, healing circles and program videos, will assist individuals greatly towards "Strengthening the Healing Journey". Individuals will attend Alcoholic/Narcotics Anonymous meetings within the facility.

The cultural component of our program is a set of traditional activities that seek to integrate traditional native practices. This includes: Traditional Ceremonies, Foods and Native Languages, Beading/Craft work, Singing, Drumming and Cultural Exchange.

Mental Health Services: Our mental health worker helps individuals deal with mental health issues such as anxiety, PTSD, phobias, etc.

1.0 Please inform your client that we do random searches and drug testing.

2.0 Eligibility Criteria

As part of the application process and before an application will be considered, all applicants MUST agree to provide a "Contact Telephone Number & Email address and location in which to have our Pre-Treatment Assessment & After-Care Counsellor contact them.

Eligibility to our program extends to individuals 18 years of age or more, and our facility is accessible to physically disabled/challenged persons.

- 2.1 Applicant must be of aboriginal status, as reflected by a Band, Treaty or Beneficiary Number, or otherwise recognized of aboriginal status by their community. Priority will be given to completed files and our catchment area, Kaneshatake, Kahnawake, Akwesasne and Montreal.



3.0 Admission Procedures

- 3.1 Admission into treatment is based on an application, which must include the following documents:
- Application for Admission
 - Provide copies of Status/Beneficiary and/or a letter from their respective community stating Proof of Status, Health Cards and/or temporary coverage.
 - Medical Examination must include Tuberculosis test results and medication list printout from your pharmacy
 - Authorization for Release of Personal Information
 - Informed Consent and Participation Agreement
 - Pre-Treatment Assessment (Mandatory telephone interview)
 - Self-Referral will be accepted, however, the client must have an emergency contact person identified.
- 3.2 Applications coming from the legal or penal system, require the following additional information:
- 3.2.1 Official legal summary of past/present sentences and charges pending.
- 3.2.2 Confirmation to go on supervised outings, as per his/her/their legal conditions (medical needs)
- 3.2.3 Available psycho-social information, including family and social background, current behaviour, etc.
- 3.3 House Requirements are also enclosed in this kit on **Pages 19 & 20**. The Referral Worker sends this completed Informed Consent and Participation Agreement with the other admission documents to the Intake Worker.
- 3.4 For Intake Decisions, files will be considered complete **ONLY** once the Application & Telephone Interview are complete. All Applications **MUST** be completed including all medical test results (2) **TWO WEEKS** before the assessment telephone interview.

Application Procedure:

Review of file by intake worker to ensure application is complete, contact referral for any missing or additional information.

1. Medical team review
2. Mental health worker review
3. Assessment counsellor for telephone assessment interview
4. Clinical team review for decision of acceptance and intake date
5. File is returned to intake worker to contact referral or client with decision



OHL COVID PROTOCOLS

- 3.5 Clients who apply to OHL must agree to undergo COVID-19 testing on the 5th & 10th day of their stay at OHL as well as if they develop symptoms of COVID-19.
- 3.6 Clients who develop COVID-19 while at OHL agree that they must either isolate in their room or may return home to isolate until they are cleared to return by public health.
- 3.7 Clients agree that they will inform OHL ASAP, should they develop symptoms of COVID-19 during their stay at OHL. They may be placed in preventative isolation until COVID-19 has been ruled out.
- 3.8 On Intake Monday, new individuals are asked to arrive according to their transportation schedules. They must do a COVID-19 Rapid Test with a **NEGATIVE** result within 48 hours of arrival to OHL.
- 3.9 On arrival, a COVID-19 Rapid Test, Plus drug testing, screening, temporal temperature reading, and bag check will be done.
- 3.10 An Orientation session will be done on Tuesday morning following intake.
- 3.11 Outside communications: Individuals are permitted daily phone privileges & internet access according to the weekly schedule. **Client Visitors on 4th & 5th Sunday 1-4pm.** (subject to change based on COVID measures in place at the time).

Client signature is required, confirming that you have read and agree to our COVID-19 Safety Measures, Information & Requirements.

MANDATORY CHECK LIST (please ensure to provide the following information in your application for admission):

- Status/Beneficiary Card or letter from Band Membership – Proof of Status
- Health Care Card or temporary # with the expiration date.
- All test results
- Medication List
- Court Conditions, if applicable
- Travel Arrangements (Arrival)

Client Signature (type your name if filling in form on your computer)

Date (dd/mm/yyyy)

checking this box verifies your signature when filling in the form on your computer



In-House Intake Schedule 2026

Intake Days	Graduation	Admin Weeks
January 12, 2026	February 19, 2026	January 5-9, 2026
March 9, 2026	April 16, 2026	February 23-27, 2026
May 4, 2026	June 11, 2026	March 2-6, 2026
July 20, 2026	August 27, 2026	April 20-May 1, 2026
September 7, 2026	October 15, 2026	August 31-September 4, 2026
November 2, 2026	December 10, 2026	October 19-30, 2026 December 14-18, 2026



APPLICATION FOR ADMISSION

In-Take Date (dd/mm/yyyy): _____

Application Date (dd/mm/yyyy): _____

Are you a former client? Yes No

Family Name: _____

Given name: _____

Gender: Male Female Other

Mailing Address: _____

City: : _____

Province (or State): _____

Postal (Zip) Code: _____

Country: _____

Tel. / Cell No. _____

Applicant's email address: _____

PRE-TREATMENT TELEPHONE INTERVIEW AND MANDATORY CONTACT

Date of birth (dd/mm/yyyy): _____ Age: _____

Nation name or village of origin: _____

Nation: _____

PHOTO COPY OF THE STATUS & HEALTH CARD ARE MANDATORY

If a copy of the Status/Beneficiary Cards are unavailable, a Letter of Affiliation from their respective community is required.

Band number: _____ Please use your 10 digit band number if applicable

Medicare number _____ Province: _____

Expiry date (month/year): _____



IDENTIFICATION OF REFERRAL WORKER:

Name: _____

Title: _____

Mailing Address: _____

City: _____

Province (or State): _____

Postal (Zip) Code: _____

Country: _____

Tel. / Cell No. _____

Email address: _____

CURRENT SITUATION OF THE INDIVIDUAL

Level of Education

Primary

Secondary - indicate year complete _____

College / University / Trade - indicate degree or certificate obtained _____

Languages Spoken: _____

Marital Status

Single

Married

Separated

Widowed

Common Law

Divorced

Income Source

Employed

E.I.

Social Assistance

Training / School

Is your attendance required by your spouse or partner: Yes No

Spouse's Name (if applicable): _____

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Housing

with spouse and children with friends alone
with spouse / partner with children other
(specify) _____

Family

Number of children: _____ Ages of children: _____

Are any of your children under Youth Protection or other childcare services: Yes No

Under voluntary measures(dd/mm/yyyy) Since: _____ Until: _____

By court decision Since: _____ Until: _____

Foster Care Since: _____ Until: _____

If the above is applicable, please fill out the following:

Name of Social Worker: _____

Title: _____

Mailing Address: _____

City: _____

Province (or State): _____

Postal (Zip) Code: _____

Country: _____

Tel. / Cell No. _____

Email address: _____

Is your attendance to treatment required by Youth Protection of other Childcare services:

Yes No

Describe in your own words what led to Youth Protection becoming involved:



LEGAL SITUATION OF THE INDIVIDUAL

Previous Convictions (Legal Documents Required)

Is your attendance to treatment required by the legal system? Yes No

Have you ever been arrested? Yes No

Conviction History

Date of Sentence	Nature of Offence	Nature of Sentence	Dates or Current Status

Current Legal Status

Not applicable

- On probation (dd/mm/yyyy) Since: _____ Until: _____
- On parole Since: _____ Until: _____
- On temporary absence Since: _____ Until: _____
- Residing in half-way house Since: _____ Until: _____
- Inmate in detention centre Since: _____ Until: _____
- Awaiting parole board decision Date scheduled: _____
- Awaiting trial / sentence Date scheduled: _____
- Charges pending
- Court conditions

Reason for conviction or charges leading to above situations:

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If applicable provide a photocopy of the Parole Certificate / Court Mandate.

Probation Officer's Name: _____

Tel. / Cell No. _____

Fax No. _____

Lawyer's Name: _____

Tel. / Cell No. _____

Fax No. _____

Please check the box below.

To avoid client's treatment interruption, any probation meetings must be done by Zoom or telephone

NOTES TO REFERRAL WORKER

1. Please ask your client to sign an **Authorization for the Release of Personal Information** form and send us the following documentation when applicable:
 - A) Official documents such as Voluntary Measures, Court Orders, Parole Board Decisions, Probation Orders, Temporary Absence Authorizations, a summary of current or past sentences and of charges pending;
 - B) Recent psycho-social assessments or progress reports (such as case summaries, etc.).
2. In cases of Parole/Probation/Youth Protection Measures, please provide information on condition(s) related to treatment.
3. Comments, if any, on the legal or penal situation of your individual:



ALCOHOL and DRUG USE

List substances that you are currently using.

last 30 days _____
Last 6 months _____
Last 12 months _____

Have you used any resources to stop using substances?

- AA/NA
- Residential treatment
- Outreach / Outpatient services

Have there been times when you were able to stay sober? Yes No

For how long? _____

Who or what did you find helpful?

The referral worker may comment here on the use of substances reported by the individual.



DOCTOR or RN MEDICAL EXAMINATION

Please fill out completely in clear print.

Full Name of Patient _____

Date of Birth (dd/mm/yyyy): _____

Medicare Number: _____ Expiry date (month/year): _____

Onen'to:kon Healing Lodge will only allow prescribed medication to be dispensed. We recommend that patients see their physicians to be reassessed, prior to admission.

Do you recommend an assessment? Yes No

Is the patient physically fit? Yes No

Height (ft/in): _____ Weight(lbs): _____

Is the patient currently experiencing health problems? Yes No

If so please specify: _____

1. Medical History

Medical Problems: Diabetes Epilepsy Asthma Others

If other please specify: _____

Surgeries: _____

Gyn-obstetrical: _____

Traumas / Disabilities: _____

List prosthetics used: _____

Allergies: _____

DO you require a specialized diet (i.e. Diabetic, intolerances, Celiac, vegetarian, allergies, etc)?

If yes, please describe:

Degree of allergy: Severe Mild

Needs an EpiPen: Yes No



Other (deafness / blindness):

2. Contagious Conditions need to be reported.

HIV AIDS Scabies Lice Tuberculosis

Hepatitis: _____

STI's: _____

Other: _____

We strongly recommend applicants undergo COVID-19 and Influenza vaccination before coming to OHL. This is an important means to protect yourself, other clients, and OHL staff.

Covid-19 and Influenza

Have you received the COVID-19 vaccine? 1 dose 2 Doses

Have you received an updated influenza vaccine Yes No

If so please attach proof of vaccination.

Mandatory Tuberculosis Test (PPD) – The PPD result must be within the last 12 months.

Report results if PPD Test : _____ mm

If the PPD reading is higher than 20 mm, we require a chest x-ray.

Date of test: (dd/mm/yyyy): _____

3. Mental Health Issues – History and treatment

Has the patient been diagnosed with mental health issues? Yes No

Please indicate past history of hospitalizations, diagnoses, treatments, and their results. Including recent mental difficulties, suicidal ideas, or attempts (e.g.: dates, methods & interventions); please include a more detailed psychiatric report.



4. Please indicate the mental health care professionals who are working with the individual.

Name: _____

Title: _____

Tel. / Cell No. _____

Email address: _____

Name: _____

Title: _____

Tel. / Cell No. _____

Email address: _____

5. Is there any current medical follow up required for any of the above-mentioned issues?

6. Is the patient currently on any withdrawal medication such as:

Suboxone

Methadone

Ativan

Other: _____

7. Mandatory - please send pharmacy print out of all current medications

8. Has the patient ever experienced any of the following? (Check all that apply)

Seizures

Delerium Tremens (D.T.'s)

Overdose (OD)

Visual hallucinations

Auditory hallucinations

Tactile hallucinations (feeling things under or on the skin)

Drug induced psychosis



9. Withdrawal difficulties (detoxification requiring medical supervision in a hospital or a Detox Centre prior to admission into treatment). Are withdrawal symptoms to be expected for this patient?

Yes No

If yes, is medically supervised detox recommended prior to admission?

10. Please note current concerns that should be taken into account in the treatment of this patient such as O.D.'s, diabetic crisis, heart problems, suicide attempts, etc.:

Doctor/Nurse Name: _____

Title/Function: _____ Date (dd/mm/yyyy): _____

Telephone #: _____ Ext.# _____

Signature: _____

(type your name if filling in form on your computer)

checking this box verifies your signature when filling in the form on your computer

I, the undersigned, authorize the health professional identified above, to submit the results of this medical examination to Onen'tó:kon Healing Lodge, for the purposes of my application for treatment.

Signature of Patient

Date (dd/mm/yyyy)

(type your name if filling in form on your computer)

checking this box verifies your signature when filling in the form on your computer



CONSENT FOR RELEASE OF INFORMATION

Referral to release to Onen'to:kon Healing Lodge

I, _____ hereby consent voluntarily for the following:

(Individual's Name)

_____ to release information regarding all aspects of my

(Referring agency(ies) and/or person)

clinical record regarding addictions, legal matters, medical, psychological & psychiatric history.

(Other information)

to Onen'to:kon Healing Lodge.

Onen'to:kon Healing Lodge to Release

Furthermore, I _____ hereby consent to Onen'to:kon

(Individual's Name)

Healing Lodge to release information to: _____

(Agency/Persons)

Regarding:

- | | | |
|-----------------|----------------------|---------------------------------|
| Progress Report | Completion Summary | Notification of early departure |
| Aftercare Plan | Reason for Departure | Medical |
| Mental Health | Other: _____ | |

Name of Individual: _____

Date of Birth (dd/mm/yyyy): _____

Signature of Individual (type your name if filling in form on your computer)

Print

I understand that:

- The information being released between the referring agency(ies) and/or person(s) is to assist me in my treatment.
- Any other information will not be released to any other persons without my consent unless it is information that the Onen'to:kon team is obligated by law to release.
- This consent lasts for the **duration of the application and treatment process.**

checking this box verifies your signature when filling in the form on your computer

Start Date(dd/mm/yyyy): _____ 6 months

End Date (dd/mm/yyyy): _____



INFORMED CONSENT AND PARTICIPATION AGREEMENT

I, the undersigned, know that the program involves:

- **WHEN REQUIRED:** Wearing a protective mask at all times, hand sanitizing, social distancing & completing a daily health check to be given to the nurse on a daily basis; (refer to COVID Protocols found on Page 4 – Section 3.7 to 3.11)
- Sharing personal matters in individual counselling and in Healing Circles;
- Reading and written assignments; attend meetings, lectures and films;
- Active involvement in household and maintenance chores;
- Participating in social and recreational activities;
- Participation in the Cultural component of our program;
- Developing an After-Care Plan;

Therefore, I shall at all times indemnify and hold harmless Onen'tó:kon Healing Lodge, its Board of Directors, Executive Director, Clinical Staff, Support staff and Administration from and against all claims, actions, suits, losses, costs, or damages that could be made or brought by myself or a third party, as a result of an act or omission on my part or others, during my participation with Onen'tó:kon Healing Lodge and thereafter all in accordance with Article 3.11 of the Onen'tó:kon Healing Lodge Policies. *(Article 3.11 – Board of Directors - Indemnity: The Organization (OHL) will indemnify its Board Members, Officers, Director or employees, all costs or expenses up to but limited by the ONEN'TO:KON HEALING LODGE insurance coverage, arising from a civil, criminal or administrative lawsuit of which they are party to, except if these persons have committed a grave error, gross negligence or fraudulent act.)*

Signature

Date (dd/mm/yyyy)

(type your name if filling in form on your computer)

checking this box verifies your signature when filling in the form on your computer



FOR REFERRAL WORKER (MANDATORY)

Referral Worker's Comments and Recommendations:

I recommend this individual for treatment.

Referral Worker's Signature

(type your name if filling in form on your computer)

checking this box verifies your signature when filling in the form on your computer

Date (dd/mm/yyyy)



Please Give to Individual

Personal items to bring

- Personal Identification
- Medicare/Health Card
- Status/Beneficiary Card
- Bank/ATM/Credit Card(s)
- Parole/Probation Papers
- Calling cards for the pay phones (CiCi Quebec is recommended)
- Smokers need to bring cigarettes.
- Cell phone, laptop/tablet, bring your own charger/adaptor(s).

Clothing

- Please bring clothes appropriate to the season
- Gym clothes and non-scuff running shoes
- Underwear, pyjamas, nightgowns, socks, stockings, slippers and/or moccasins.
- Appropriate footwear/clothing for outdoor cultural activities.
- Graduation attire

The following are not allowed

- Mouthwash with alcohol
- Clock radios
- Glue (any kind)
- Individuals are not permitted to leave their vehicle at the Onen'tó:kon Healing Lodge, for the duration of their stay.
- Chewing tobacco, cigars, snuff.

Medication

- All medication brought to the Center is to be handed in to staff and will be monitored by the Nurses.
- Some prescribed medication, such as ointments, asthma medication, etc., will be handed back to the individual after medical team review.

Dress Code

- The purpose of our Dress Code is to promote healthy and respectful boundaries. Inappropriate clothing will be addressed. Any clothing that promotes drugs/alcohol, sexism, violence or racism will be placed in safe keeping.
- For safety reasons, footwear (slippers, shoes, running shoes) must be worn at all times.
- T-shirts must be worn at all times (e.g.: for exercising, outside, etc.)
- Individuals must be out of sleepwear (pyjamas) and dressed before Morning Welcome.



House Requirements

House Requirements seek two (2) purposes: (a) set boundaries that will promote safe and harmonious group life for everyone, and (b) to encourage individuals to develop self-discipline, a sense of responsibility and respect of oneself and of others. Respect of and meeting House Requirements also reflects client's motivation.

Any OHL Staff member has the authority to dismiss an individual with approval from Administration and/or Supervisor.

Behaviours that may result in dismissal are as follows:

- Using alcohol and/or other drugs during treatment;
- Purposely and consistently withdrawing oneself from any program activities in a major and significant way.
- Leaving the premises.
- Criminal offences (such as theft, threats, or physical violence);
- Any sexual activity or sexual harassment towards staff or clients.

Concerning Program or Scheduled Activities

- PUNCTUALITY: Individuals attend program or scheduled activities, on time.
- TELEPHONE USE WHILE IN TREATMENT:
 - We ask that each individual be civil to the person on the phone, during your conversation.
 - Inappropriate behavior (swearing/yelling) will NOT be tolerated, and it will be brought to your attention by a staff member. This may result in your call being terminated immediately should this behavior continue.
 - Please respect the confidentiality of being in Treatment on your Social Media (Facebook, Tik Tok, Instagram, Messenger, etc.)
 - Repeated behavior will also be recorded and placed in the client file for reference.
 - Personal devices will be allowed to be used only during SCHEDULED time.
 - No telephone use during program time.
- Fifteen (15) minutes of Chores is carried out three (3) times a day, according to the schedule.
Individuals are to keep themselves busy for the full Fifteen (15) minutes.

Concerning Responsibility and Respectful Manners

- Individuals need to show respect to other individuals and staff.
- Defacing, graffiti or vandalizing any of Onen'to:kon's property (furniture, books, etc.) is not acceptable behaviour. Individuals who deliberately break or destroy any property of Onen'to:kon Healing Lodge, must reimburse, repair or cover the replacement costs.
- **Other individuals' bedrooms are off limits.**



Concerning Health and Safety

- Smoking is authorized on personal time only and restricted to the back outdoor porch, except during scheduled Alcoholics Anonymous/Narcotics Anonymous (AA/NA) Meetings where smoking is permitted at the AA entrance.
- Fire Drills are mandatory, and everyone must evacuate the building.
- Unplug all electric hair styling tools when not in use. (Curling/straightening irons, hair dryers, etc.)

In order to keep our staff and clients safe, we will have Mandatory Covid Safety Protocols in place.

Outside Communications - Telephones and Mail

- Outgoing calls are made with the public telephones in the hall near the elevator and main entrance.
- Staff takes incoming calls: all messages are passed on to individuals.
- Individual's incoming personal mail is to be opened in the presence of a Staff member.
- Personal devices will be made available during specific scheduled time and place.



Client Medical Agreement

Name: _____

Date: ____/____/____

I am aware that I am responsible for taking medication as prescribed by my attending physician and that I must comply with any brought in during my stay at the Onen'to:kon Healing Lodge.

In addition, I must bring all items necessary for the maintenance of my health, such as a glucometer with needles and strips to test my sugar, if diabetic or an EpiPen if I have allergies.

I agree to consult a medical professional should staff deem it necessary for my wellbeing. (example: nurse/doctor/dentist/psychologist/psychiatrist).

Client signature:

Referral signature: