9HIS GIRLS DISCIPLESHIP

This form MUST be filled out and submitted to be considered for acceptance.
Please press firmly so this can be read if scanned and emailed.

Date:_____

Name: Birthdate:

Emergency Contact:

Relationship: Phone:

Emergency Contact:

Relationship: Phone:

Note: Information may be shared with any person listed as an emergency contact, including if you exit the program.

How did you hear about us?

ISSUES.

Circle all that apply: Alcohol Cigarettes Drugs Prostitution
Pornography Violent Relationships Other

Probation/Parole? Probation officer and phone number:

Do you have Community Service?

County of: Outstanding Warrants?

List all criminal convictions with brief description, date of conviction and where:

Your Religious preference: Do you belong to a church?

Church Name and address and Pastor's name

Physician name and phone:

Mental Health History:

Are you presently taking medication? What are they & for what?

We are NOT a shelter. We are NOT a Medical Facility. We are NOT a Detox or Rehab Center. We are NOT a halfway house.

We are a non-smoking facility.

We ARE a one-year residential Christian Discipleship Program for women in crisis that would like to change their lives

ADDICTION SCREENING TOOL

Client Name: Date:

County of Residence: (Circle) Manatee County Sarasota County Homeless Other

ALCOHOL/ DRUG HISTORY / USE

1. Have you ever used (circle all that apply):

Alcohol Marijuana Cocaine/Crack Tobacco Heroin Prescribed Methadone Non-prescribed Methadone Other Opiates Ecstasy Hallucinogens- LSD, Mushrooms PCP/Angel Dust Methamphetamine Other Amphetamines a Benzodiazepines-Valium, Xanax, Librium, Ativan Barbiturates Inhalants Spice Flakka Other:

2. Do you currently use tobacco?

3. When and why do you use: Circle all that apply:

Morning mostly with others mostly alone to fall asleep when tense/unhappy despite an illness although it interferes w/your social/occupational functioning because of hallucinations (voices, etc.) because of manic feelings or depression

Age of first use? How used (smoked, inhaled, injected, by mouth)

Age of regular use? What is your drug of choice?

Usual amount when using and how often:

Date of last use:

Tobacco Alcohol Marijuana Cocaine/crack Heroin Rx Methadone Non Rx Methadone Other opiates Ecstasy Hallucinogens PCP/ Angel Dust Methamphetamine Other amphetamine Benzodiazepine Barbiturates Inhalants

4. Has the amount used to get the desired effect increased?

5. Have you tried to cut back? If yes, how?

6. Do you ever drink or use when you have not planned to?

7. How have you been able to support your alcohol and other drug use?

8. Have you ever overdosed on drugs?

9. Have you ever experienced withdrawal symptoms?

10. Are you currently experiencing withdrawal symptoms?

11. How is your behavior different when you drink or use than when you're not drinking or using?

12. Would you describe your chemical use as: Circle all that apply:
problem for me problem for others both no problem

13. Has alcohol and/or drug use caused problems in any of the following: family relationships, friendships, living situations, job/vocational performance, sexual relationships, spiritual/religious beliefs, education, physical health or legal issues? Please explain.

14. How many of your friends use alcohol/drugs? Few Some Most All None

15. Have you lost any friends to alcohol or drug use? How many?

16. Who is the person closest to you?
Does he/she use drugs?

17. Has your ability to be close to anyone been affected by your alcohol and drug use? Explain:

18. Describe your present peer group: size of group, gender balance, activities, and amount of alcohol/drug use.

19. Describe your spiritual beliefs and support system.

20. What was your family's belief about alcohol/drug use? Does anyone use? If so, who?

21. What are your beliefs about alcohol/drug use?

22. What helps you the most not to use drugs or alcohol?

23. What is the longest time you have remained clean and sober?

24. Have you received any treatment for alcohol/drug problems? If so, where and when?

If yes, how many times? When was the last time?

25. Types of treatment?

Inpatient Outpatient Intensive Outpatient Program Residential Program Halfway House

26. How long did you stay sober/clean after last treatment?

Why do you feel it did not work?

27. Have you ever been seen by a psychiatrist, psychologist, and/or a mental health professional even as a child?

If so, when and for what?

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28. Have you ever been on any medications for mental health problems such as depression, anxiety, mood disorders?

If so please list the medications, when you were on them, and why.

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29. If you were on medication was it helpful? Why or why not?

30. Do you have any history of seeing or hearing things while NOT under the influence of drugs and/or alcohol?

31. Have you ever received continual medical treatment and if so for what?

32. Have you been diagnosed and/or treated for (circle all that apply) HIV Hep C TB Diabetes Heart Problems High Blood Pressure Lung Problems Liver problems Kidney Problems Vision Problems Hearing problems Asthma Stroke Stomach Problems Chronic Pain Arthritis Anemia Cancer

33. Please list all medications you are taking or should be taking, and why.

Signature:_____

Date: _____

ACCOUNTABILITY:

I voluntarily submit my person, as well as any of my belongings to random searches. I will participate in random Urinary Analysis and Alcohol testing while I am in His Girls' Discipleship Program. I am willing to be an accountability sister at all times.

Signature:_____ Date:

Interviewer: Date:

MAIL POLICY:

No in or outgoing mail is allowed in the first 30 days. Incoming and outgoing mail after the first 30 day period is subject to screening by the staff. Only staff will have access to our mailbox, so please refrain from going in and out of mailbox. This is in place to protect all the residents of the house. If you should leave the program residence, your mail will be returned to sender. We will not save or forward your mail when you leave. It is your responsibility to change your address.

Signature: Date:

Interviewer: Date:

VOLUNTEER PROGRAMS/ WORK THERAPY:

I understand that volunteer programs and community service blessings are work therapy and are a mandated as part of my program. The goal is to learn a good work ethic, connect and bless our community. I learn to walk out the precepts of the Bible in my life and bless others. There is no compensation for volunteer projects.

Signature: Date:

Interviewer: Date:

WAIVER OF TENANCY: Waiver of the Landlord-Tenant Act:

The organization His Helping Hands Ministries, Inc. DBA His Girls' Discipleship is a non-profit charitable organization that has been certified by the State of Florida and oversees the guidelines and by laws of the ministry. In this situation, the residents are a part of the ministry home, voluntarily, only as part of the recovery program and for no other reason. At any time, we reserve the right to ask a resident of the program to leave, if they violate any rules, refuse to participate in any or all assigned program functions, which they agree to when they entered the program residence. I have read this statement and agree to waive my rights as a tenant.

Signature: _____ Date: _____

Interviewer: _____ Date: _____

RELEASE OF INFORMATION FORM - DEPARTMENT OF CORRECTIONS:

I give my consent for His Helping Hands Ministries, Inc. DBA His Girls' Discipleship to release any information to the State of Florida Department of Corrections that pertains to the resident while enrolled in this program.

Signature: _____ Date: _____

Interviewer: _____ Date: _____

RELEASE OF INFORMATION FORM - DEPARTMENTS OF HEALTH & SOCIAL SERVICES & DEPARTMENT OF CHILDREN AND FAMILIES:

I give my consent for His Helping Hands Ministries, Inc. DBA His Girls' Discipleship to release any information to the State of Florida Departments of Health, Social Services and Department of Children and Families that pertain to benefits, services, requirements and guidelines that I may be responsible for while I am enrolled in the program.

Signature: _____ Date: _____

Interviewer: _____ Date: _____

CONSENT FOR PHOTOGRAPHS:

I understand that while at His Helping Hands Ministries, Inc. DBA His Girls' Discipleship photos and/or video may be taken during services, programming or outreach events. I give my permission to His Helping Hands Ministries, Inc. DBA His Girls' Discipleship to use in print, video, website, internet social sites and for general use whether I continue or discontinue my residence in the program.

Signature: _____ Date: _____

Interviewer: _____ Date: _____

<u>ALL</u> FORMS MUST BE SIGNED TO ENTER OUR PROGRAM.

HIS GIRLS' DISCIPLESHIP

PROGRAM FEE AGREEMENT

The cost of living at HIS GIRLS' DISCIPLESHIP, is a fee of $400 per month, due on the 1st of each month. This includes housing, utilities, clothing, teaching and program activities. We are NOT responsible for the theft or loss of your pocket money. All program fees are non-refundable (regardless of any reason, including but not limited to a resident not staying less than 24 hours ... All fees are non-refundable).

Please check one of the following options for your Program Fee of $400/ month.

I receive a fixed monthly income check in the amount of: $_____.

Source of fixed income: Disability_____Social Security_____Unemployment_____ Alimony_____

I have the ability to pay the Program Fee in full ($400/ monthly)

I have the ability to pay a portion of the Program Fee: $_____

I do NOT have the ability to pay, but have a sponsor and/or a family member that is willing to pay $_____ , until I go to work after 90 days, with permission.

Sponsor Name/Address/Phone

_____

Relationship to You: _____

I do hereby agree to the following terms for my program fee payments. I understand that if I leave for any reason or I am required to leave the program, all program fees are NON-REFUNDABLE regardless of the circumstances.

Signature: _____ Date: _____

Interviewer: _____ Date: _____