INTRODUCTION

Thank you for your interest in applying to The Grace House program. **Please read all of the information carefully including this brief introduction.**

Mission Statement and Organization:

- The Grace House is a non-profit organization.
  The Grace House, Women's Residential program offers a faith based program for transitional housing. This is a residential, 5 Phase program designed to equip each lady with the tools they need to establish them for future success, and for them to live a life free from drugs. We offer a safe and secure environment while they work towards goals specific to each womans needs. These include but are not limited to paying fines, obtaining a drivers license and completeng any court ordered classes, or probation.

Our Program Structure

We are a Christ-centered nonprofit, so our program features proven Bible based curriculum from the Recovery Bible. Because it's based on the Word of God, our program changes more than learned behavior. We believe It transforms hearts, thus bringing healing and freedom to hurting women, with the results being a turn around in their entire lives. **:**

Commitment:

- This application assists us in determining if we can meet your specific need for help. If for some reason we cannot, we may be able to refer you to another organization.
- Applicants to The Grace House should have a desire for help in a Christian atmosphere and should be willing to apply the principles of a biblical counseling program.
- Women applying to The Grace House cannot be placed at The Grace House involuntarily by parents or outside agencies and must desire true change in their life. The desire for personal change plays a significant part in the healing process while at The Grace House. Applicants accepted to The Grace House program will be asked to sign a 30 Day Commitment form prior to entry.
- Generous individuals give to The Grace House so that women can find freedom and healing. As stewards of these gifts and to be accountable to our donors, we want to ensure that each bed is filled with someone who wants help and is willing to work through the program.
- Applicants must determine if they are willing to commit to The Grace House program. Once an applicant has completed the application process, is accepted into the program, and enters The Grace House, **she has only one opportunity to come to The Grace House.**

If a resident decides to leave the program prematurely or is discharged due to not complying with program expectations, she will be given an opportunity to re-apply to The Grace House in 6 months.

We are here for you and desire to work with you in this process, but you have to make the choice to commit. You have an opportunity to completely change your life forever.

Personal Spending Money While at The Grace House

The Grace House request that each resident or her parent/guardian to be responsible for her personal expenses, whether through insurance, sponsorship, governmental benefits, or personal contribution. While the ministry generously provides the counseling program, food, and living accommodations, **we are not a medical facility and we cannot be responsible for a resident's previous debt or third-party service expenses such as doctors' appointments, hospitalizations, and medication costs incurred while the resident is living at our home..** You are asked to arrange in advance for your personal expenses and have these funds sent to you on a monthly basis in order to maintain your Personal Spending Account.

At minimum, incoming residents will be required to bring $100 ** with them for their Personal Spending Account and must have that amount replenished if/when it is depleted. Your personal expenses may include, but are not limited to:

- Travel to/from The Grace House
- Pens and paper
- Toiletries (deodorant, makeup, etc.)
- Stamps
- Clothing, if needed
- One meal per week (on shopping day)

The Grace House recommends that residents anticipate needing approximately $100 per month to maintain/replenish their Personal Spending Account.

In addition, some women entering the program may have personal spending needs that relate to third-party expenses and should have a financial plan in place to cover these types of needs at The Grace House . These types of expenses may include, but are not limited to:

- Monthly doctors' visits to monitor medication
- Prescription refills/medication costs
- ER visits/hospitalizations, if needed
- Additional doctors' visits, if you become ill or require medical attention

A resident's personal medical needs could exceed the recommended amount for a Personal Spending Account and can vary significantly based on insurance coverage, current prescriptions and medications, and medical needs during the program. During the application process, The Grace House Intake staff can give general guidelines to applicants regarding a suggested monthly amount to have available for medical needs based on each applicant's specific situation. The Grace House Intake staff may recommend an applicant anticipate additional funds necessary due to medical needs that are present at time of application.

** **$100.00 If any available Vouchers, they may be applied for by the applicant.**

INSTRUCTIONS

Step 1 **Application Form** – Complete Part One of the application (pages 1 – 7). The application must be completed by the applicant and filled out completely.
Please submit pages 1-7 of the application to the Assistant Director, Alice Ottinger.

Photograph – Along with Part One of the application, please send a recent head-to-toe photograph taken within the last three months to the Assistant Director, Alice Ottinger.

Step 2 **Family & Medical History –** Please complete pages 11 through 15 in your own handwriting; submit these pages to the Assistant Director upon completion.

Phone Interview – It is the applicant's responsibility to call Chelsea, Director to schedule a telephone interview. Interviews last approximately 20-30 minutes and are scheduled in advance.

Please complete this application in your own handwriting. *This information is confidential.* We will share information that is pertinent to your application *process* with those to whom you give us permission by signing a Release of Information as well as the individual who referred you to the program, on an as needed basis.

A "Release of Information Form" is found as the last page of this application. Please completely fill out this Release Form including the names of individuals whom you would like to allow access to information about your application *process*.

When completing your application below, please answer all questions honestly so we may know how best to help you. Please do not leave any blanks in your application. If a question is not applicable to you please put N/A.

Please be sure to write your first and last name in the spaces provided.

Name: _____ Date: _____ Preferred Name: _____

Present Address: _____

City: _____State/Province: _____ Zip/Postal Code: _____

Country:_____

Primary Phone #: (_____)_____ Secondary Phone #: (____)_____

E-mail:_____

Mother's Name: _____ Father's Name: _____

Legal Guardian's Name

_____

Address: _____

City: _____State/Province:_____ Zip/Postal Code: _____

Primary Phone #: (_____)_____ Secondary Phone #: (____)_____

How did you hear about The Grace House ? (Check all that apply)

☐Parents ☐Church ☐Radio/TV ☐Internet ☐Court ☐Counselor ☐Friend ☐Other (specify)_____

With your permission we will share information regarding your application process with those whom you authorize via the Release of Information form (p.20) as well as your referral source.

Date of Birth: _____ Age: _____

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other (specify)_____

Are you a U.S. citizen? ☐ Yes ☐ No If no, please explain:_____

City, State/Province, and Country of Birthplace: _____

Social Security Number: _____

Physical Characteristics: Height: _____ Weight: _____

Marital Status (Please check one)

☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced

If engaged, how long? _____ is a wedding date set? _____ If yes, when is the wedding date? _____

If married, for how long? _____

Children

If you have children, list names and ages:

1. _____ Age: _____
2. _____ Age: _____
3. _____ Age: _____
4. _____ Age: _____

Who has custody of your children? _____

What arrangements are being made for your children while you are at The Grace House?_____

_____

Will your coming to The Grace House have any effect on your custody status? Yes No

If yes, explain: _____

Pregnancy

Are you pregnant? ____ Yes _____ No If Yes, give approximate due date:_____

Has a doctor confirmed your pregnancy? Yes ____ No ___

Is the birth father aware of your pregnancy? Yes ____ No ___

Which are you considering? (Please check one) Parenting ____ Placing for Adoption ___ Undecided _____

The Grace House firmly believes in allowing you to make the choice between parenting your child or adoption. We believe that while you are here God will give you direction for your life and that of your unborn child. If you have already made a decision to place your child for adoption we will support you 100% as you prepare for this precious event.

EDUCATION

Did you graduate from High School? Yes ___ No ____

If No, would you be interested in pursuing your GED? ___Yes ____ No

Medical

Do you have any allergies (food, medicine, animal)? _____Yes_____ No

List all known allergies: _____

_____

Do you require an EpiPen? Yes No

List any and all medication or supplements that you take:

Medication/Supplement	Dosage	Reason	For How Long

If you have been prescribed medications, please do not stop them on your own. Continue to take them as prescribed by your physician(s). The Grace House is not a medical facility and will require a statement from the doctor/psychiatrist/specialist who prescribed your medication fully explaining the need for this (these) prescription(s).

List any dietary restrictions/limitations: _____

_____

Were these restrictions/limitations recommended by a doctor? ☐ Yes ☐ No

If the scheduled meal does not fit into your diet, we offer peanut butter sandwiches.

Do you have, or have you ever had, a problem with food or eating? ☐ Yes ☐ No If yes, explain:

_____

Have you been diagnosed or treated by a physician for an eating disorder ☐ Yes ☐ No

If yes, provide doctor's name: _____ and telephone #: (_____)_____

List any physical limitations and/or medical conditions (asthma, migraines, thyroid, diabetes, blood pressure, heart problems, etc.) that you may have as indicated by a physician: _____

_____

List all past surgeries or medical hospitalizations (include dates and reasons for hospital stays): _____

_____

_____

Financial

Are you on government or financial assistance? ☐ Yes ☐ No

Will your coming to The Grace House have any effect on this assistance? Yes ☐ No

Do you have any outstanding debts? ☐ Yes ☐ No If yes, explain: _____

_____

What arrangements will you make for their payment while you are in the program? _____

_____

Who will assist you with finances for your personal and/or third-party medical needs while at The Grace House (church, ministry, family, or individual)? _____

_____

Legal Background

Have you ever been arrested? ☐ Yes ☐ No How many times? _____ Dates, charges, etc.: _____

_____

Do you have any pending court dates? ☐ Yes ☐ No If yes, explain: _____

Are you currently incarcerated? ☐ Yes ☐ No How long? _____ Length of time remaining? _____

Name of Attorney or Legal Representative: _____

Attorney's telephone #: (_____)_____

Are you currently on: Probation? ☐ Yes ☐ No Parole? ☐ Yes ☐ No

If so, how long? _____ Length of time remaining: _____

Substance Use

Check any substances with which you have experimented.

☐ Alcohol	☐ Hallucinogenic (Acid, LSD, etc.)		☐ Other: _____
☐ Amphetamines (uppers)	☐ Crank	☐ Morphine	☐ Other: _____
☐ Barbiturates (downers)	☐ Crystal Meth	☐ Opium	☐ Other: _____
☐ Cocaine	☐ Marijuana	☐ Heroin	☐ Other: _____
☐ Crack	☐ Methamphetamine	☐ Ecstasy	☐ Other: _____
☐ Inhalants (Glue, Paint Thinner, etc.		☐ Tobacco	☐ Other: _____

Drug of Choice:

1)_____ Length of Use _____ Date Last Used _____

2)_____ Length of Use _____ Date Last Used _____

Counseling and Treatment

Have you ever been diagnosed or treated for:

ADD/ADHD	☐ Yes	☐ No	Obsessive Compulsive Disorder	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Oppositional Defiant Disorder	☐ Yes	☐ No
Asperger's Syndrome	☐ Yes	☐ No	Post Traumatic Stress Disorder	☐ Yes	☐ No
Bi-Polar Disorder	☐ Yes	☐ No	Reactive Attachment Disorder	☐ Yes	☐ No

Borderline Personality Disorder	☐ Yes	☐ No	Schizoaffective Disorder	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Schizophrenia	☐ Yes	☐ No
Dissociative Identity Disorder	☐ Yes	☐ No			

Have you ever dissociated (a state of involuntary separation from reality caused by stress or trauma)?

☐ Yes ☐ No If yes, briefly explain: _____

_____

Have you been in any in/outpatient counseling therapy in the last 2 years? ☐ Yes ☐ No (Please list facilities/counselors below)

Please list any type of care you have received within the last 2-3 years that fall within these general categories: psychiatrist care, psychiatric hospital, counseling/therapy, rehabilitation center of any kind, dietitian oversight, substance detoxification program, etc.

Date of Entry	**Counselor or Program Name**	**City/State or Province**	**Reason for Leaving**	**Date of Discharge**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Personal History

Have you ever tried to commit suicide? Yes No When?_____ How? _____

Why? _____

Have you ever self-harmed? ☐ Yes ☐ No How? _____

At what age did you start and is this a current struggle? _____

Ever required medical treatment for self-harm? ☐ Yes ☐ No

Have you ever been a victim of rape? ☐ Yes ☐ No Age? _____

Have you ever been the victim of sexual abuse? ☐ Yes ☐ No Age? _____

Have you ever been the victim of physical abuse? ☐ Yes ☐ No Age? _____

Have you ever been involved in prostitution? ☐ Yes ☐ No

Have you ever experienced confusion about your sexuality? ☐ Yes ☐ No If yes, explain:

_____

Spiritual

Have you ever committed your life to God? Yes No

Date: _____ Place: _____

In what denomination/church affiliate were you raised? _____

How active were your parents in their faith and beliefs? _____

Do you regularly attend a church? ____ Yes ____ No

Do you read the Bible? ____ Yes___ No How often? _____

Do you ever pray? ____Yes ____ No

What is your present relationship with God? _____

_____

Have you ever witnessed or been involved in occult activities ___ Yes _____ No

If yes, write a detailed explanation of your involvement with occult activities: _____

_____

_____

_____

Have you ever been abused during any of these activities? Yes No If yes, explain: _____

_____

_____

_____

Tell us why you would like to come to The Grace House.

_____

_____

_____

_____

What are the top 3 areas you want to work on while at The Grace House?

☐Anger	☐ Legal Issues	☐ Sexual Abuse	☐ Other: _____
☐Anxiety	☐ Occult	☐ Suicidal Thoughts	☐ Other: _____
☐Chemical Dependency	☐ Pregnancy	☐ Bi-polar Disorder	☐ Other: _____
☐Depression	☐ Self-Harm	☐ OCD	☐ Other: _____
☐Eating Disorder	☐ Physical Abuse	☐ PTSD	☐ Other: _____

What would you like to see happen as a result of coming to The Grace House? _____

_____

_____

_____

DECLARATION

By signing below, I am indicating that the info I have provided is truthful to the best of my knowledge and I have not knowingly withheld information.

Signature: _____

Print Name: _____

Date: _____

GENERAL EXAM

NOTE TO PHYSICIAN: For your convenience, if your office has a standard general exam form, it may be used instead of this form. Simply attach the completed document from your office to this form.

Name of Applicant: _____

General Appearance:

Height _____ Weight _____

Vital Signs:

Blood Pressure _____ Temp. _____

Pulse _____ Resp. _____

Eyes: Appearance of Vision

Without Glasses R-20 _____ L-20_____

With Glasses R-20 _____ L-20_____

Teeth: Appearance of Teeth

Dental Curves etc. _____

Ears: Appearance

RTM _____ LTM _____

Right Ear Canal _____ Left Ear Canal _____

Nose:

Throat:

Cardiovascular:

Neurological:

GI/GU:

Extremities:

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

Physician's Address: _____

Physician's Phone# _____

IF YOU ARE PREGNANT

(To be completed by your physician)

Name of Applicant: _____

Gynecological exam: Date of LMP _____

Results of Pelvic Exam: Cervix _____

Uterus _____

Vagina _____

Breasts: Shape and appearance of breasts and nipples _____

_____

Pregnancy: Date of LMP _____ Weight _____

Due Date _____

Fundal Height _____ Cervix _____

Ultrasound Results (if done): _____

Any abnormalities such as vaginal bleeding or vaginal secretions no related to a normal pregnancy? If so, what?

_____

_____

Recommendations for care (bed rest, physical limitations, dietary limitation, etc.): _____

_____

Were any medications prescribed, if so what and for what reason? _____

_____

Physician's impressions, comments, and diagnosis of applicant's health: _____

_____

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

Physician's Address: _____

Physician's Telephone #: (_____)_____

MEDICAL HISTORY

(To be completed by the applicant)

Name of Applicant: _____

It is important that we receive as much medical information as possible from residents entering The Grace House. Please check yes or no to each medical condition and **if you check yes, please explain your symptoms in the same box as the condition and write your age at the time of illness.**

CONDITION	YES	NO
Severe or persistent headaches		
Blurred vision or eye pain		
Hearing loss		
Hay fever/seasonal allergies		
Sinus trouble		
High or low blood pressure (specify)		
Severe chest pain		
Heart palpitations		
Heart trouble		
Asthma or shortness of breath (specify)		
Swelling of ankles		
Leg cramps		
Teeth or jaw pain/discomfort		
Lacerations (indicate where located)		
Scales/sores (ongoing or difficult to heal)		
Digestive tract problems		
Rheumatic fever		
Blood in urine or burning upon urination		
Frequent kidney infections or kidney stones		
Vomiting blood		

CONDITION	YES	NO
Diarrhea or constipation (specify)		
Arthritis		
Blackout spells/fainting		
Convulsions/Seizures/Epilepsy		
Dizziness		
Chronic/excessive fatigue		
Often depressed		
Frequent trouble sleeping		
Bruise easily		
Blood transfusion		
Infectious diseases such as Scarlet Fever, Measles, Chicken Pox, Mumps		
Infectious diseases such as Whooping Cough, Smallpox, Typhoid Fever		
Cancer		
Anemia		
Diphtheria		
Hepatitis		
Tuberculosis		
Pneumonia		
Nervous Breakdown		
Goiter		
Sexually transmitted diseases (Syphilis, Gonorrhea, Herpes)		
HIV-AIDS		

Indicate any other past or present illness(es) not listed: _____

List all current prescribed medication as well as supplements you take: _____

List all medication allergies and/or sensitivities: _____

Do you have a regular menstrual cycle? ☐ Yes ☐ No If no, please explain: _____

_____

Days between periods: _____ How many times have you been pregnant? _____

Number of miscarriages: _____ Number of full-term deliveries: _____

Number of preterm deliveries (less than 37 weeks): _____

FAMILY HISTORY

(Whether living or deceased)

Relative/Name	Age	Condition of Health	Age at Death	Cause of Death
Mother:				
Father:				
Sisters:				
Brothers:				
Children:				
List known Birth Family (if adopted)				
Birth Mother:				
Birth Father:				
Birth Siblings:				

Medical Insurance Information Form
Section A

1. Name, address and telephone number of family practitioner:
   _____
   _____

2. Do you have current individual insurance coverage? ☐ Yes ☐ No

   Dental _____ Vision _____ Medical _____

   OR

   If you are a dependent, are you covered by your parent/legal guardian's policy? ☐ Yes ☐ No

   Dental _____ Vision_____ Medical _____

3. Social Security Number of policy holder: _____

4. Date of birth of policy holder: _____

Please call your insurance provider for assistance in answering the following questions. If you do not have insurance, please proceed to Section B of this form.

5. Name of insurance provider: _____

   Policy number: _____ Group number: _____

6. Does your policy provide medical coverage outside of your network for both emergency and non-emergency visits? ☐ Yes ☐ No If yes, what % does it cover? _____

7. What is your doctor visit co-pay inside of the network? _____ Outside of the network? _____

8. Do you have prescription drug coverage? ☐ Yes ☐ No

   If yes, are prescriptions covered outside of the policy network? ☐ Yes ☐ No What %? _____

9. Will your insurance policy cover all the following possible medical needs while at The Grace House ? Please check all that are covered:

   ☐ Normal Pregnancy* ☐ Complicated Pregnancy*
   ☐ Emergency Room ☐ Hospitalization
   ☐ Lab Work ☐ Psychiatric Visits

***Please note that coverage for these needs is only required for applicants who are pregnant.**

The Grace House will require your insurance, prescription, and social security cards upon arrival into the program to assist with processing medical claims. No copies please.

Medical Insurance Information Form
Section B

Throughout your stay at The Grace House, you are responsible to pay your own expenses from any third-party medical needs that may arise, whether through insurance (if applicable), sponsorship, government benefits, and/or personal contribution.

In summary:

1. **Personal Spending Accounts are set up to assist all residents with covering personal needs and third-party medical expenses. The account must be replenished as needed (more frequently, if receiving psychiatric services). Any remaining balance will be returned to the resident upon departure from the program.**
2. **If you are not pregnant and have no means of financial support in providing your medical expenses, please contact the Assistant Director.**
3. **If you are pregnant, our Assistant Director will help you apply for insurance with state Medicaid after you arrive. If you are not accepted for state insurance, then you will be responsible for any and all medical bills.**
    - **(For pregnant applicants) I agree with The Grace House on the importance of me making the right decision with God's guidance for me and my baby's future without pressure from others. Should I decide to place my baby for adoption, I understand that the adoptive couple will assume all pregnancy related costs.**

Remember, the resident is responsible for any third-party medical costs for services used outside of The Grace House program, and that are not covered by insurance. Please be aware that the initial (and ongoing) costs for psychiatric visits and prescriptions (whether a resident has full or partial insurance coverage) will vary and can quickly deplete a resident's spending account due to higher charges in some cities.

All applicants please read and sign the following:

I _____ (print name), have read the above information. I also understand that the total of all third-party medical expenses acquired while staying at The Grace House is my responsibility to pay in full (except if pregnant and choosing adoption).

_____ _____

Applicant's Signature Date

RELEASE OF INFORMATION FORM

All matters relating to applicant records and information are considered confidential and are treated as such by the staff of The Grace House. Information regarding such matters cannot be given without the written consent of the applicant or parent/guardian.

Name of Applicant: _____ DOB: _____

I, _____, do hereby give permission for The Grace House to share information related to my application to the program with:
(For example, you may want to include family members, youth workers, etc.)

1. _____
2. _____
3. _____
4. _____

I also give the following professional(s), pastoral staff, and/or facility(ies) permission to exchange the following information with The Grace House for the purpose of application to the program.

1. _____
2. _____
3. _____
4. _____

☐ medical records and information ☐ personal history information
☐ educational information and records
☐ psychological records, psychiatric records, discharge summaries, treatment records and summaries, counseling records

This release will expire on (date) _____ unless written notification by the applicant or parent/guardian (if applicable) indicates otherwise.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Witness **(Required)** Date
Must be an individual other than those listed above

FOR OFFICE USE ONLY

NOTES: