

## Harvest House Transitional Centers: Women with Children

### APPLICATION/REQUIREMENTS for ADMISSION

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**PURPOSE:** Harvest House serves to empower women and their children distressed by life destroying problems to become responsible, functioning families in their communities.

**PROGRAM:** Harvest House provides an opportunity for a new life conforming to right moral standards in a home-like environment.

**COST:** The cost per week is \$150.00 for the 1<sup>st</sup> child, \$165.00 for the 2<sup>nd</sup> child, and \$175.00 for the 3<sup>rd</sup> and 4<sup>th</sup> child. The program fee is non-refundable.

**ACCOUNTABILITY:** Residents develop a Christian character of respect, integrity, and humility as they honor the program structure of Harvest House; i.e. *Progressive Four Phase Program, Daily Schedule, House Rules, Cause for Disciplinary Discharge, etc.* as well as staff directives.

#### **GUIDELINES:**

- A. Commit to four months of residency with expectations of residing no more than twelve months.
- B. Honor House Rules and staff directives with diligence and respect.
- C. Break from dysfunctional people, places, and things that brought you to Harvest House.
- D. Submit to a search of your person, possessions, and bodily fluids upon arrival, or at anytime thereafter, while a resident of Harvest House.
- E. Surrender all money to your Harvest House escrow account upon receipt/return to the house; agree NOT to utilize a bank/credit/debit cards or accounts while a resident of Harvest House.
- F. Harvest House reserves the right to discharge any resident at anytime for not complying with the Code of Conduct or Program Description. Leave without disruption to staff or other residents if discharged by staff.

If you share the perspective offered by Harvest House, you are welcome to make official application for admission by signing below. Your signature denotes that you have voluntarily and free of coercion, read and agree to submit to the authority of Harvest House as referenced in this document. Upon the review of your completed application and the available bed space you will be notified as to acceptance. To contact HHTC: Women with Children directly call (941) 953-3154.

Please remember to enclose the proper release form from your contact person (lawyer, case worker, probation officer, Chaplain, counselor, family member, friend, other).

Applicant's Name (PRINT): \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Anticipated Admission Date: \_\_\_\_\_ Time: \_\_\_\_\_

Staff Approval: \_\_\_\_\_ Date: \_\_\_\_\_

**INTAKE FORM**

IDENTIFICATION INFORMATION

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

SS#: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Age: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_

Living with: \_\_\_\_\_ Relationship: \_\_\_\_\_

Spouses Name: \_\_\_\_\_ Address: \_\_\_\_\_

No. of Children: \_\_\_\_\_

What languages do you speak?: \_\_\_\_\_

Give a one word description of your life now: \_\_\_\_\_

**CHILDREN**

How many children do you have? \_\_\_\_\_ How many will move in Esther's Place with you? \_\_\_\_\_  
(Max 4)

List Children below:

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>D.O.B.</u>	<u>Social Security #</u>	<u>In school/daycare?</u>	<u>Where?</u>
<u>1</u>					Y N	
<u>2</u>					Y N	
<u>3</u>					Y N	
<u>4</u>					Y N	

**FINANCIAL ASSISTANCE**

Please circle the following financial assistance you are currently receiving and the amount per month:

SSI \$ \_\_\_\_\_ Other? \_\_\_\_\_ \$ \_\_\_\_\_

SSDI \$ \_\_\_\_\_

Food Stamps \$ \_\_\_\_\_

WIC \$ \_\_\_\_\_

HUD \$ \_\_\_\_\_

Cash Assistance \$ \_\_\_\_\_

**FAMILY HISTORY**

Father's Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone#:(\_\_\_\_) \_\_\_\_\_

Describe your relationship with your father is one phrase: \_\_\_\_\_

How often do you have contact with him?: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone#:(\_\_\_\_) \_\_\_\_\_

Describe your relationship with your mother is one phrase: \_\_\_\_\_

How often do you have contact with her?: \_\_\_\_\_

Where were you born? \_\_\_\_\_ Who raised you?: \_\_\_\_\_

Were you adopted?: \_\_\_\_\_ At what age?: \_\_\_\_\_

Which parent were you most comfortable with?: \_\_\_\_\_

Are your biological parents divorced?: \_\_\_\_\_

If ever, how many times did you run away from home?: \_\_\_\_\_ Ages: \_\_\_\_\_

Has any of your family members been in jail?: \_\_\_\_\_ Who?: \_\_\_\_\_

Has any of your family members been in a mental hospital?: \_\_\_\_\_ Who?: \_\_\_\_\_

Are any of your family members addicted to drugs/alcohol/pills?: \_\_\_\_\_

If so, who?: \_\_\_\_\_

Name your siblings and their age:

\_\_\_\_\_  
\_\_\_\_\_

Was there violence in your home growing up?: \_\_\_\_\_ Between who?: \_\_\_\_\_

Were you ever abused as a child: Physically? \_\_\_\_\_ Emotionally? \_\_\_\_\_ Sexually? \_\_\_\_\_

If so, by who?: \_\_\_\_\_

**MARITAL HISTORY (including Common Law relationship)**

If not married, are you involved in an intimate relationship?: \_\_\_\_\_

With who?: \_\_\_\_\_ Address?: \_\_\_\_\_

Name of current and previous spouse(s)  
(including common law)                      Length of  
Marriage                      No. of  
Children                      Common  
Law?

Name of current and previous spouse(s) (including common law)	Length of Marriage	No. of Children	Common Law?

Have

Have you ever abused your husband? Y of N Physically \_\_\_\_\_ Emotionally \_\_\_\_\_

Have you ever been separated?: \_\_\_\_\_ If yes, explain: \_\_\_\_\_

What were some of the issues of conflict in your marriage?: \_\_\_\_\_

\_\_\_\_\_

**EDUCATIONAL HISTORY**

What was the last grade you completed?: Grade \_\_\_\_\_ College \_\_\_\_\_ Other \_\_\_\_\_

Did you like school?: \_\_\_\_\_ How did you do?: \_\_\_\_\_

Do you have any future educational goals?: \_\_\_\_\_ What?: \_\_\_\_\_

**PREVIOUS COUNSELING HISTORY**

Have you ever gone for counseling?: \_\_\_\_\_ When?: \_\_\_\_\_

Where?: \_\_\_\_\_

For what?: \_\_\_\_\_

Are you currently receiving help from another professional?: \_\_\_\_\_ Who?: \_\_\_\_\_

Have you ever attempted suicide?: \_\_\_\_\_ Has anyone in your family?: \_\_\_\_\_

Has anyone in your family ever been diagnosed mentally ill?: \_\_\_\_\_

**CRIMINAL JUSTICE SYSTEM**

Charges Pending: \_\_\_\_\_

City: \_\_\_\_\_ Judge: \_\_\_\_\_ Next hearing date: \_\_\_\_\_

Are you n Probation or Parole? (circle one) Date of Sentencing: \_\_\_\_\_

Probation Officer: \_\_\_\_\_ Phone No. of PO: \_\_\_\_\_

Address of PO: \_\_\_\_\_

Terms of Probation/Parole: \_\_\_\_\_

Ever violated?: \_\_\_\_\_ When?: \_\_\_\_\_

Prior Criminal History:

Date	City	Charge	Disposition

Attorney/Public Defender's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Appointed or Retained (circle one) \_\_\_\_\_

**Have you ever been required to register as a sex offender?** \_\_\_\_\_

**SUBSTANCE ABUSE HISTORY**

Check all that you have abused and when:

DRUG	USED		HOW OFTEN <u>Frequency</u>	HOW LONG <u>Duration</u>
	<u>Past</u>	<u>Present</u>		
<u>Alcohol</u>	_____	_____	_____	_____
<u>Marijuana</u>	_____	_____	_____	_____
<u>Hash</u>	_____	_____	_____	_____
<u>Hallucinogenic</u>	_____	_____	_____	_____
<u>Barbiturates</u>	_____	_____	_____	_____
<u>Amphetamines</u>	_____	_____	_____	_____
<u>Heroin</u>	_____	_____	_____	_____
<u>Methadone</u>	_____	_____	_____	_____
<u>Cocaine</u>	_____	_____	_____	_____
<u>Other?</u>	_____	_____	_____	_____

Have you used alcohol in the last 7 days?: \_\_\_\_\_ When?: \_\_\_\_\_

Is alcohol your drug of choice?: \_\_\_\_\_

Have you used a drug in the last 7 days?: \_\_\_\_\_ What?: \_\_\_\_\_ When?: \_\_\_\_\_

What is your drug of choice (excluding alcohol)?: \_\_\_\_\_

**QUESTIONS:**

Do you feel drinking is problem for you? Y N

I've been concerned about my drinking for some time. Y N

Have you ever tried to cut down or stop drinking? Y N

Has drinking ever caused difficulty in your life? Y N

Have you ever been arrested under the influence? Y N

Have you ever needed more alcohol to get the same affect? Y N

Has anyone ever complained about your drinking? Y N

Have you ever felt guilty or ashamed for drinking? Y N

How old were you when you first noticed your problem?: \_\_\_\_\_

Have you ever tried to cut down or stop using drugs? Y N

When?: \_\_\_\_\_

**EMPLOYMENT HISTORY**

What is your most recent employment status?: \_\_\_\_\_

Where?: \_\_\_\_\_ Position/Title: \_\_\_\_\_

LIST YOUR 5 MOST RECENT JOBS:

Employer	Position	Time Frame (dates)	Reason for leaving	Attitude toward job

What kind of work are trained to do?: \_\_\_\_\_

What kind of work are you interested in?: \_\_\_\_\_

Why?: \_\_\_\_\_

**YOUR HEALTH AND MEDICAL INFORMATION**

Doctor's Name: \_\_\_\_\_  
Doctor's Address: \_\_\_\_\_  
Doctor's Phone #: \_\_\_\_\_  
Medical Insurance: Yes or No Policy #: \_\_\_\_\_

When did you last see a Doctor? \_\_\_\_\_ For What? \_\_\_\_\_  
Have you ever used needles? \_\_\_\_\_ Number of sexual partners? \_\_\_\_\_  
Have you ever participated in homosexual activity? \_\_\_\_\_ When? \_\_\_\_\_

Have you had an HIV test? \_\_\_\_\_ When? \_\_\_\_/\_\_\_\_/\_\_\_\_ Result?: \_\_\_\_\_

Have you had any other S.T.D. tests? \_\_\_\_\_ When? \_\_\_\_/\_\_\_\_/\_\_\_\_ Result?: \_\_\_\_\_  
Treatment history? \_\_\_\_\_

Is it possible that you are pregnant?: \_\_\_\_\_

Have you taken any medication in the last year? \_\_\_\_\_

What: \_\_\_\_\_ When: \_\_\_\_\_

\*\* Please list all medication you are currently taking:

\_\_\_\_\_

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Are you on a special diet? \_\_\_\_\_ If so, what? \_\_\_\_\_

Please list any current allergies or physical complaints/problems: \_\_\_\_\_

\_\_\_\_\_

Check symptoms you currently have:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Upset stomach   |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Bleeding        |
| <input type="checkbox"/> Mental Illness       | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Excess fatigue  |
| <input type="checkbox"/> Chronic cough        | <input type="checkbox"/> DT's               | <input type="checkbox"/> Depression      |
| <input type="checkbox"/> Dermatitis           | <input type="checkbox"/> Rapid weight loss  | <input type="checkbox"/> Epilepsy        |
| <input type="checkbox"/> Dental problems      | <input type="checkbox"/> VD or Herpes       | <input type="checkbox"/> Back problems   |
| <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> HIV (AIDS)         | <input type="checkbox"/> Hearing loss    |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Liver problems     | <input type="checkbox"/> Hepatitis       |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Heart disease   |
| <input type="checkbox"/> Open sores           | <input type="checkbox"/> Bone or joint pain | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Constipation         | <input type="checkbox"/> Chest pain         | <input type="checkbox"/> other           |

Explain above symptoms:

\_\_\_\_\_

\_\_\_\_\_

Have you ever been diagnosed with a mental illness? \_\_\_\_\_ What? \_\_\_\_\_  
When? \_\_\_\_\_ What medication was prescribed? \_\_\_\_\_

**Child #1 HEALTH AND MEDICAL INFORMATION**

Child Name: \_\_\_\_\_

Case Worker's Name & Number: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's Phone #: \_\_\_\_\_

Medical Insurance: Yes or No Policy #: \_\_\_\_\_

When did he/she last see a Doctor? \_\_\_\_\_ For What? \_\_\_\_\_

Has he/she had an HIV test? \_\_\_\_\_ When? \_\_\_\_/\_\_\_\_/\_\_\_\_ Result?: \_\_\_\_\_

Is it possible that she is pregnant?: \_\_\_\_\_

Has he/she taken any medication in the last year? \_\_\_\_\_

What: \_\_\_\_\_ When: \_\_\_\_\_

\*\* Please list all medication he/she is currently taking:

\_\_\_\_\_

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Is he/she on a special diet? \_\_\_\_\_ If so, what? \_\_\_\_\_

Please list any current allergies or physical complaints/problems: \_\_\_\_\_

\_\_\_\_\_

Check symptoms he/she currently has:

___ Allergies	___ Dizziness	___ Upset stomach
___ Asthma	___ Insomnia	___ Bleeding
___ Mental Illness	___ Digestive problems	___ Excess fatigue
___ Chronic cough	___ DT's	___ Depression
___ Dermatitis	___ Rapid weight loss	___ Epilepsy
___ Dental problems	___ VD or Herpes	___ Back problems
___ Diarrhea	___ HIV (AIDS)	___ Hearing loss
___ High blood pressure	___ Liver problems	___ Hepatitis
___ Difficulty breathing	___ Tuberculosis	___ Heart disease
___ Open sores	___ Bone or joint pain	___ Vision problems
___ Constipation	___ Chest pain	___ other

Explain above symptoms:

\_\_\_\_\_

\_\_\_\_\_

Has he/she ever been diagnosed with a mental illness? \_\_\_\_\_ What? \_\_\_\_\_

When? \_\_\_\_\_ What medication was prescribed? \_\_\_\_\_

**Child #2 HEALTH AND MEDICAL INFORMATION**

Child Name: \_\_\_\_\_

Case Worker's Name & Number: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's Phone #: \_\_\_\_\_

Medical Insurance: Yes or No Policy #: \_\_\_\_\_

When did he/she last see a Doctor? \_\_\_\_\_ For What? \_\_\_\_\_

Has he/she had an HIV test? \_\_\_\_\_ When? \_\_\_\_/\_\_\_\_/\_\_\_\_ Result?: \_\_\_\_\_

Is it possible that she is pregnant?: \_\_\_\_\_

Has he/she taken any medication in the last year? \_\_\_\_\_

What: \_\_\_\_\_ When: \_\_\_\_\_

\*\* Please list all medication he/she is currently taking:

\_\_\_\_\_

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Is he/she on a special diet? \_\_\_\_\_ If so, what? \_\_\_\_\_

Please list any current allergies or physical complaints/problems: \_\_\_\_\_

\_\_\_\_\_

Check symptoms he/she currently has:

___ Allergies	___ Dizziness	___ Upset stomach
___ Asthma	___ Insomnia	___ Bleeding
___ Mental Illness	___ Digestive problems	___ Excess fatigue
___ Chronic cough	___ DT's	___ Depression
___ Dermatitis	___ Rapid weight loss	___ Epilepsy
___ Dental problems	___ VD or Herpes	___ Back problems
___ Diarrhea	___ HIV (AIDS)	___ Hearing loss
___ High blood pressure	___ Liver problems	___ Hepatitis
___ Difficulty breathing	___ Tuberculosis	___ Heart disease
___ Open sores	___ Bone or joint pain	___ Vision problems
___ Constipation	___ Chest pain	___ other

Explain above symptoms:

\_\_\_\_\_

\_\_\_\_\_

Has he/she ever been diagnosed with a mental illness? \_\_\_\_\_ What? \_\_\_\_\_

When? \_\_\_\_\_ What medication was prescribed? \_\_\_\_\_

**Child #3 HEALTH AND MEDICAL INFORMATION**

Child Name: \_\_\_\_\_

Case Worker's Name & Number: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's Phone #: \_\_\_\_\_

Medical Insurance: Yes or No Policy #: \_\_\_\_\_

When did he/she last see a Doctor? \_\_\_\_\_ For What? \_\_\_\_\_

Has he/she had an HIV test? \_\_\_\_\_ When? \_\_\_\_/\_\_\_\_/\_\_\_\_ Result?: \_\_\_\_\_

Is it possible that she is pregnant?: \_\_\_\_\_

Has he/she taken any medication in the last year? \_\_\_\_\_

What: \_\_\_\_\_ When: \_\_\_\_\_

\*\* Please list all medication he/she is currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Is he/she on a special diet? \_\_\_\_\_ If so, what? \_\_\_\_\_

Please list any current allergies or physical complaints/problems: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Check symptoms he/she currently has:

- |                           |                         |                      |
|---------------------------|-------------------------|----------------------|
| ____ Allergies            | ____ Dizziness          | ____ Upset stomach   |
| ____ Asthma               | ____ Insomnia           | ____ Bleeding        |
| ____ Mental Illness       | ____ Digestive problems | ____ Excess fatigue  |
| ____ Chronic cough        | ____ DT's               | ____ Depression      |
| ____ Dermatitis           | ____ Rapid weight loss  | ____ Epilepsy        |
| ____ Dental problems      | ____ VD or Herpes       | ____ Back problems   |
| ____ Diarrhea             | ____ HIV (AIDS)         | ____ Hearing loss    |
| ____ High blood pressure  | ____ Liver problems     | ____ Hepatitis       |
| ____ Difficulty breathing | ____ Tuberculosis       | ____ Heart disease   |
| ____ Open sores           | ____ Bone or joint pain | ____ Vision problems |
| ____ Constipation         | ____ Chest pain         | ____ other           |

Explain above symptoms:

\_\_\_\_\_  
\_\_\_\_\_

Has he/she ever been diagnosed with a mental illness? \_\_\_\_\_ What? \_\_\_\_\_

When? \_\_\_\_\_ What medication was prescribed? \_\_\_\_\_

**Child #4 HEALTH AND MEDICAL INFORMATION**

Child Name: \_\_\_\_\_

Case Worker's Name & Number: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Doctor's Phone #: \_\_\_\_\_

Medical Insurance: Yes or No Policy #: \_\_\_\_\_

When did he/she last see a Doctor? \_\_\_\_\_ For What? \_\_\_\_\_

Has he/she had an HIV test? \_\_\_\_\_ When? \_\_\_\_/\_\_\_\_/\_\_\_\_ Result?: \_\_\_\_\_

Is it possible that she is pregnant?: \_\_\_\_\_

Has he/she taken any medication in the last year? \_\_\_\_\_

What: \_\_\_\_\_ When: \_\_\_\_\_

\*\* Please list all medication he/she is currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Is he/she on a special diet? \_\_\_\_\_ If so, what? \_\_\_\_\_

Please list any current allergies or physical complaints/problems: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Check symptoms he/she currently has:

____ Allergies	____ Dizziness	____ Upset stomach
____ Asthma	____ Insomnia	____ Bleeding
____ Mental Illness	____ Digestive problems	____ Excess fatigue
____ Chronic cough	____ DT's	____ Depression
____ Dermatitis	____ Rapid weight loss	____ Epilepsy
____ Dental problems	____ VD or Herpes	____ Back problems
____ Diarrhea	____ HIV (AIDS)	____ Hearing loss
____ High blood pressure	____ Liver problems	____ Hepatitis
____ Difficulty breathing	____ Tuberculosis	____ Heart disease
____ Open sores	____ Bone or joint pain	____ Vision problems
____ Constipation	____ Chest pain	____ other

Explain above symptoms:

\_\_\_\_\_  
\_\_\_\_\_

Has he/she ever been diagnosed with a mental illness? \_\_\_\_\_ What? \_\_\_\_\_

When? \_\_\_\_\_ What medication was prescribed? \_\_\_\_\_