

HARVEST HOUSE TRANSITIONAL CENTERS
VA GRANT & PER DIEM PROGRAM
APPLICATION/REQUIREMENTS for ADMISSION

PURPOSE: Harvest House serves to empower Veterans distressed by life destroying problems to become responsible, functioning individuals in their communities.

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

COST: Per Diem funds cover housing & treatment costs.

ACCOUNTABILITY: Residents develop a 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 twelve months of residency with a maximum of 24 months of residency.
- 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. Agree to a search of your person and possessions upon arrival, or at anytime thereafter, while a resident of Harvest House. Agree to random urinalysis and upon request.
- E. Veteran will set up escrow account with the purpose of saving towards independent living. Classes in money management skills will be provided.
- F. Harvest House reserves the right to discharge any resident at anytime for not complying with the Code of Conduct or Program Description. If discharged, agree to leave without disruption to staff or other residents.

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 the guideline of Harvest House as referenced in this document and release Harvest House to acquire information from Department of Veteran Affairs to determine eligibility. Upon the review of your completed application and the available bed space you will be notified as to acceptance. To contact HHTC VA Program call (941) 953-3154, fax (941) 954-2349, email harvesthousecenters@hotmail.com.

Applicant's Name (PRINT): _____

Applicant's Signature: _____ Date: _____

Anticipated Admission Date: _____ Time: _____

Staff Approval: _____ Date: _____

ALL SECTIONS AND QUESTIONS MUST BE COMPLETED IN ORDER TO PROCESS APPLICATION

INTAKE FORM

PERSONAL INFORMATION

Date: _____
First Name: _____ Last Name: _____ M.I.: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____
SS#: _____ Sex: _____ Citizenship: _____
Age: _____ D.O.B.: _____ Marital Status: _____ Race: _____
Adult Education: HS Diploma Some college AA BA/BS MA/MS PhD Technical
Are you a veteran? _____ Do you have your DD 214? _____
Type of Discharge: _____ Have you served in active duty? _____
Give a one phrase description of your life now: _____

FINANCIAL ASSISTANCE

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

SSI	\$ _____.	VA Benefits	\$ _____.
SSDI	\$ _____.	Employment	\$ _____.
Food Stamps	\$ _____.	Other? _____	\$ _____.
Cash Assistance	\$ _____.		

VA SERVICES

Are you registered with a VA Medical Center or CBOCH? _____
Are you receiving a pension? _____ If so, how much monthly? _____

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?: _____

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? _____ Do you smoke cigarettes? _____

Have you had an HIV test? _____ When? ____/____/____ Result?: _____

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

Have you taken any medication in the last year? _____
If so, what: _____ When: _____

** Please list all medication you are currently taking:

Are you on a special diet? _____ If so, what? _____

Please list any current allergies or physical complaints/problems: _____

Check symptoms you currently have:

- | | | |
|---------------------------|-------------------------|----------------------|
| ____ 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 |
| ____ Arthritis | | |

Explain above symptoms:

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

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? _____

If yes, when was it and what were the charges? (use space provided below)

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>Hallucinogenic</u>	_____	_____	_____	_____
<u>Barbiturates</u>	_____	_____	_____	_____
<u>Amphetamines</u>	_____	_____	_____	_____
<u>Methamphetamines</u>	_____	_____	_____	_____
<u>Heroin</u>	_____	_____	_____	_____
<u>Methadone</u>	_____	_____	_____	_____
<u>Cocaine</u>	_____	_____	_____	_____
<u>Oxy/Roxy</u>	_____	_____	_____	_____
<u>Benzodiazepines</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)?: _____

List 3 goals you hope to achieve by participating in this program:

1) _____

2) _____

3) _____

Additional Notes:

All questions and sections must be completed for this application to be processed. Please return your application to Admissions via mail at 209 N Lime Ave Sarasota, FL 34237, via fax (941) 954-2349, via scan and email to harvesthousecenters@hotmail.com

Thank you for your interest in our program and thank you for serving our country.