<u>Harvest House Transitional Centers</u>

SINGLE MEN & WOMEN
APPLICATION/REQUIREMENTS for ADMISSION

PURPOSE: Harvest House serves to empower individuals 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 $140.00 for women and $175.00 for men. Those without funds will be entered on account until employed, but if possible, we ask that one to two weeks program fee be paid up front. (Expected as per adjustment within one week). The program fee and initial payment is non-refundable.

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 nine months of residency with the goals of independent & sober living.
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. Resident will set up escrow account with the purpose of saving towards independent living.
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 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 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:__________________

IDENTIFICATION INFORMATION

Date:________________________

First Name:_________________________ Last Name:_______________________ M.I.:______

Currently Homeless: Y N If No, Address:_____________________________________

City:______________ State:________ Zip:__________ Phone:_________________________

SS#:______________________ Sex:___________ Citizenship:_________________________

Age:________ D.O.B.:______________ Marital Status:_________ Race:__________

Living with:____________________________ Relationship:________________________

Spouses Name:__________________________ Address:____________________________

No. of Children:_________________________ Are you a veteran?____________________

Level of Education:______________________

Do you have a FL I.D./D.L.: Y N Birth Certificate: Y N SS Card: Y N

What languages do you speak?:____

Give a one word description of your life now:____

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 $_______.____

If you are unable to pay your program fee who will be your guarantor to insure that it is paid?_______

____

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?_____________________________

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	HOW LONG
	Past	Present	Frequency	Duration
Alcohol	____	______	_____________	______________
Marijuana	____	______	_____________	______________
Hallucinogenic	____	______	_____________	______________
Barbiturates	____	______	_____________	______________
Amphetamine	____	______	_____________	______________
Methamphetamine	____	______	_____________	______________
Heroin	____	______	_____________	______________
Methadone	____	______	_____________	______________
Cocaine	____	______	_____________	______________
Opiates	____	______	_____________	______________
Other?____________	____	______	_____________	______________

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 alcohol/drugs are a problem for you?	Y	N
Have you ever been arrested under the influence?	Y	N
Have you ever needed more alcohol/drugs to get the same affect?	Y	N
Has anyone ever complained about your behavior?	Y	N
How old were you when you first noticed your problem?:	______________	
Have you ever tried to cut down or stop using alcohol/drugs?	Y	N

When?:_____________________

EMPLOYMENT HISTORY

Are you currently employed?________ If yes, where?:_____________________________________

Position/Title:_____________________ Name/Number of Supervisor:_________________________

LIST YOUR 3 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?:____

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? ___________
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:

____

____

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

Explain above symptoms:

____

____

____

Have you ever been diagnosed with a mental illness? ______ What? ______________________

When? _________________ What medication was prescribed? __________________________

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 Admissions at 209 N Lime Ave Sarasota, FL 34237, via fax (941) 954-2349, scan & email to harvesthousecenters@hotmail.com, or in person..

Thank you for your interest in our program. Your application will be processed within 48 hours from the time we receive it. If you do not here from our Admissions department regarding your application please feel free to contact us.