PRE-APPLICATION DISCLOSURE

HIS HOUSE FOR Her

FAITH-BASED SUPPORTIVE HOUSING FOR WOMEN

Thank you for your interest in His House for Her. Please note the following.

- Completing this application does not guarantee acceptance into the program.
- An in-depth interview will be required to adequately determine that His House for Her is able to meet your very important needs.
- The information provided on your application will be verified for accuracy and truth.

BRIEF OVERVIEW:

- His House for Her is a 4-to-12-month, faith based program.
- If approved, you will receive a thorough, trauma-informed assessment and create your own strength-based Individual Recovery Plan
- His House for Her will consult with community partners to provide a provide a multi-disciplinary approach to help you with your recovery goals.
- We are a smoke free, tobacco free and vape-free campus.
- Program fees and food costs are affordable; we will assist you in finding employment.
- His House for Her assists you with ACCESS Florida benefits.
- His House for Her conducts random 14-panel drug screens.

PROGRAM EXPECTATIONS

- His House for Her expects you to keep our residence DRUG AND ALCOHOL FREE. Refusal to submit to a drug or alcohol screen and/or dirty or diluted test results may be grounds for immediate dismissal.
- His House for Her expects you to remain free from the possession of any illegal substances, and/or drug paraphernalia <u>at all times</u> including when you are both on and off His House property. Possession of any illegal substances and/or drug paraphernalia may be grounds for immediate dismissal.
- His House for Her expects you to remain free from the possession of any and all weapons <u>at all times</u> including when you are both on and off His House property. Possession of any weapon at any time will be grounds for immediate dismissal.
- His House for Her expects you to respect the property of others by not stealing including when you are both on and off His House property. Stealing at any time may be grounds for immediate dismissal.
- His House for Her expects you to respect and abide by our house rules and structure which includes but is not limited to:
    a) limited, pre-approved visitation after initial 60 days
    b) no cell phone possession or use; approved computer use as needed
    c) limited, pre-approved personal telephone calls after the initial 30 days
    d) weekly church attendance is required
    e) adherence to the Core Values of kindness, excellence, service, accountability, and unity
- His House for Her will screen you for drugs and alcohol at the time of move-in. Should you screen positive for either, His House expects you to complete detox at a detox facility <u>before</u> being admitted to our residence.

RESIDENT APPLICATION

HIS HOUSE FOR Her

FAITH-BASED SUPPORTIVE HOUSING FOR WOMEN

Program Application—CONFIDENTIAL WHEN COMPLETED

By filling out this application, you are requesting consideration into His House for Her, Inc., a 4-to-12-month, faith-based program that will help you heal and become self-sufficient.

Completion of this application does not obligate you to receive services.
Please return this completed application to His House for Her Executive Director by email to: renee@hishouseforher.org or mail to: His House for Her, PO Box 830455, Ocala, FL 34483.

PROFILE:

DATE OF APPLICATION: _____

NAME: _____ PHONE#: _____

ADDRESS: _____ City/State/Zip _____

DOB: _____ City/State of Birth: _____ AGE: _____

RACE: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Non-Hispanic ☐ Other _____

SOCIAL SECURITY #: _____ EMAIL ADDRESS: _____

HOW DID YOU HEAR ABOUT US: ☐ Research ☐ Friend/Family ☐ Referral from: _____

IDENTIFICATION:

Are you a US Citizen? ☐ Y ☐ N Are you a Veteran? ☐ Y ☐ N

Do you possess a valid driver's license? ☐ Y ☐ N If no, please explain: _____

Do you possess a valid State ID? ☐ Y ☐ N If yes, what State? _____

Do you possess a Birth Certificate? ☐ Y ☐ N Name at Birth? _____

If no, what is the city, state & name of medical facility you were born in? _____

EMERGENCY CONTACTS:

NAME	PHONE	ADDRESS	RELATIONSHIP

PREVIOUS ADDRESS:

PREVIOUS ADDRESS: _____

Who did you live with? ☐ Spouse ☐ Life Partner ☐ Children ☐ Parents ☐ Sibling ☐ Friends ☐ Other

Would you return to the same place? ☐ Y ☐ N If no, why: _____

Would you be willing to stop associating with unsafe family or friends? ☐ Y ☐ N If no, why: _____

INCARCERATION (if applicable):

DOC Number: _____

Name & Address of Correctional Institution: _____

_____

_____

Have you been to court and been sentenced? ☐ Y ☐ N Release/End of Sentence Date: _____

Name & contact info for your institution Case Worker: _____

Current Charges: _____

How many times have you been incarcerated? _____

DATE	CHARGED WITH	JAIL OR PRISON

Have you ever been convicted of any violent charges? ☐ Yes ☐ No
Have you ever been convicted of: ☐ Assault ☐ Armed Robbery ☐ Domestic Violence ☐ Other Violent Crime
☐ Resisting Arrest with Violence ☐ Other conviction? _____
Do you have any upcoming court dates: ☐ Yes ☐ No If yes, date: _____
Do you have any outstanding warrants: ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Are you being court-ordered to a program? ☐ Yes ☐ No

LEGAL INFORMATION PROBATION INFORMATION (if applicable):

Do you have any OPEN legal cases or charges? ☐ Y ☐ N If yes, please explain: _____

_____

Are you currently on probation? ☐ Y ☐ N If so, how often do you need to report? _____

Name of Attorney or Probation Officer: _____

Phone# _____ Email: _____

I hereby authorize and consent for the above attorney to provide information about my pending legal charges including court dates, expectation of release at sentencing, release dates, or any other pertinent legal information to His House for Her, Inc.

Signature _____ Date _____

FAMILY

HUSBAND/LIFE PARTNER:

Current LEGAL Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Husband/Ex-Husband Name: _____ Partner's Name: _____

Address: _____ Phone #: _____

_____ Occupation: _____

Do they currently use drugs or alcohol? ☐ Y ☐ N Have they used drugs or alcohol in the past? ☐ Y ☐ N

Have they BEEN or are they CURRENTLY incarcerated? ☐ Yes ☐ No

If yes, please list date, charges & location of incarceration: _____

_____

Please describe your relationship with your husband or partner: _____

_____

_____

Have you had any previous legal marriages? ☐ Yes ☐ No Number of times LEGALLY married: _____

CHILDREN:

CHILD'S NAME	DOB	AGE	SEX	PRESENT LIVING SITUATION AND/OR CURRENT CAREGIVER

CHILDCARE INFORMATION:

Do you have LEGAL custody? ☐ Yes ☐ No If yes, ☐ 50/50 ☐ Full ☐ Other _____

Is there an OPEN DCF Case: ☐ Yes ☐ No Is there a case plan for reunification? ☐ Yes ☐ No

Do your children have a Case Worker? ☐ Yes ☐ No Name of Agency: _____

Name of Case Worker: _____ Phone #: _____

Do your children have Guardian ad Litem? ☐ Yes ☐ No If yes, name? _____

Phone# _____ Email: _____

Are there any restraining orders against you? ☐ Yes ☐ No

Are you responsible for child support payments? ☐ Yes ☐ No If yes, how much? _____

PARENTS:

Father's Name: _____ Address: _____ _____ Phone#: _____ Is your father living? ☐ Yes ☐ No If deceased, what year & cause of death: _____	Mother's Name: _____ Address: _____ _____ Phone #: _____ Is your mother living? ☐ Yes ☐ No If deceased, what year & cause of death: _____
Describe your relationship with your father:	Describe your relationship with your mother:

SIBLINGS:

How many brothers and sisters do you have? _____

Name: _____ Age: _____ Living? ☐ Yes ☐ No

Name: _____ Age: _____ Living? ☐ Yes ☐ No

Name: _____ Age: _____ Living? ☐ Yes ☐ No

Name: _____ Age: _____ Living? ☐ Yes ☐ No

Name: _____ Age: _____ Living? ☐ Yes ☐ No

EDUCATION:

Did you graduate from High School? ☐ Yes ☐ No If no, highest grade completed? _____

Have you received a GED? ☐ Yes ☐ No If not, have you taken any GED classes? ☐ Yes ☐ No

Have you had any technical, vocational, or college education? ☐ Yes ☐ No If yes, please list:

EMPLOYMENT HISTORY:

What is your trade/profession, if any? _____

FROM MO/YR	TO MO/YR	EMPLOYER	TYPE OF WORK	REASON FOR LEAVING

MEDICAL INFORMATION/HISTORY:

☐ I consent to provide this information. Signature: _____ Date: _____

☐ I decline to provide this information. Signature: _____ Date: _____

IF CONSENT ABOVE IS SIGNED, PLEASE ANSWER THE FOLLOWING:

Do you have Medical Insurance? ☐ Yes ☐ No If no, have you applied for Medicaid ☐ Yes ☐ No

If yes, please list Medical Insurance provider: _____

Do you have MEDICAL issues NOT currently being treated? ☐ Yes ☐ No

If yes, please list: _____

_____

Do you have DENTAL issues NOT currently being treated? ☐ Yes ☐ No

If yes, please list: _____

_____

What provisions, if any, have been made for medical or dental expenses? _____

_____

Do you wear glasses? ☐ Yes ☐ No If yes, do you need help getting glasses? ☐ Yes ☐ No

Do you wear dentures? ☐ Yes ☐ No If yes, do you need help getting dentures? ☐ Yes ☐ No

MEDICATIONS: Please list all prescribed and over-the-counter medications you are taking AT THIS TIME.

NAME OF MEDICATION	REASON FOR MEDICATION	DOSAGE HOW MUCH—HOW OFTEN

Are you currently on Opioid treatment through Medicated Assisted Treatment (MAT) program? ☐ Yes ☐ No
If yes, please "√" ☐ Subutex ☐ Suboxone ☐ Vivitrol (monthly injection) ☐ Other: _____

Do you have any physical limitations? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Do you have ANY Allergies or require a special diet? ☐ Yes ☐ No If yes, please explain: _____

Will you consent to an STI/HIV test for sexually transmitted infections? ☐ Yes ☐ No

Do you have any past or current medical problems (surgeries, dietary requirements, sexually transmitted infections, seizures, allergies, etc.) that may affect you while in the program? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any sleep disorders, nightmares, sleepwalk, sleep apnea? ☐ Yes ☐ No

If yes, please explain: _____

MENTAL HEALTH INFORMATION/HISTORY

☐ I consent to provide this information. Signature: _____ Date: _____

☐ I decline to provide this information. Signature: _____ Date: _____

IF CONSENT ABOVE IS SIGNED, PLEASE ANSWER THE FOLLOWING:

Have you ever been diagnosed with a mental illness? ☐ Yes ☐ No

If yes, please complete the following:

MENTAL HEALTH DIAGNOSIS	CURRENT MENTAL HEALTH MEDICATION	DOSAGE HOW MUCH—HOW OFTEN

Have you ever attempted suicide? ☐ Yes ☐ No If yes, how many times? _____ When? _____

If yes, please explain: _____

Have you ever been Baker-Acted? ☐ Yes ☐ No If yes, how many times? _____ When? _____

If yes, please explain: _____

Have you ever been in counseling? ☐ Yes ☐ No If yes, how many times? _____ When? _____

If yes, please explain: _____

Have you ever been admitted to an overnight mental health hospital or program? ☐ Yes ☐ No

If yes, how many times? _____ When? _____

Were you admitted ☐ Voluntarily ☐ In-voluntarily Please provide dates & explain: _____

_____

_____

_____

Have you ever had an eating disorder? ☐ Yes ☐ No If yes, ☐ Anorexia ☐ Bulimia ☐ Binge-Eating ☐ Other

If yes, please explain: _____

_____

SUBSTANCE USE

What substances have you used recently and/or in the past? Place a "√" for all that apply.

DRUG NAME	YEAR	DRUG NAME	YEAR	DRUG NAME	YEAR
☐ Alcohol		☐ Hallucinogens		☐ Mushrooms	
☐ Amphetamines		☐ Hashish		☐ Nitrous Oxide	
☐ Barbiturates		☐ Heroin		☐ Opium	
☐ Crack		☐ Inhalants Other		☐ Oxycodone	
☐ Cocaine		☐ Marijuana		☐ Rohypnol	
☐ Dilaudid		☐ Mescaline		☐ Roxicodone	
☐ Ecstasy		☐ Methadone		☐ Valium	
☐ Fentanyl		☐ Methamphetamine		☐ Xanax	

List all OTHER substances you have tried that are NOT listed in the above chart:

DRUG NAME	YEAR	DRUG NAME	YEAR	DRUG NAME	YEAR

Have you ever injected a drug? ☐ Yes ☐ No If yes, last injection date: _____

Please list what drug(s): _____

_____

Have you ever sold drugs? ☐ Yes ☐ No If yes, list what drug(s): _____

_____

How old were you when you first used drugs or alcohol? _____

What led you to start using drugs or alcohol? _____

_____

What is your drug(s) of choice? _____

What was your longest period being clean and sober? _____

Duration of being clean/sober time? _____ When? _____

What caused your relapse? _____

_____

_____

_____

What are your triggers (events/situations) that cause you to relapse? _____

_____

_____

_____

Date of last drug/alcohol use of any kind: _____ What substance? _____

SUBSTANCE ABUSE TREATMENT HISTORY

PROGRAM/REHAB NAME	LOCATION	DATES	REASON FOR D/C
			☐ Successful completion ☐ Dismissed
			☐ Successful completion ☐ Dismissed
			☐ Successful completion ☐ Dismissed
			☐ Successful completion ☐ Dismissed

YOUR PERSONAL GOALS FOR RECOVERY

Why do you want to be a part of this program? Please be specific: _____

_____

_____

_____

What do you hope to receive from this program? Please be specific: _____

_____

_____

_____

Why do you think this program's outcome will be different than others? _____

What is the longest time you have stayed in another program? _____

Why did you leave? _____

What are your personal goals for recovery? Please be specific.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Why do you feel like you are ready to make a commitment to change your life now?

What would you like to do after the completion of this program?

Please describe yourself—your personality:

SPIRITUAL LIFE

Have you ever committed your life to the God of Jesus Christ? ☐ Yes ☐ No If yes, when? _____

Did you attend church as a child? ☐ Yes ☐ No Have you attended church as an adult? ☐ Yes ☐ No

What type of church did you attend? _____

How often do you currently attend church? ☐ Weekly ☐ Couple times a month ☐ Occasionally ☐ Never

Have you ever been involved in ☐ Satanism ☐ Witchcraft ☐ Occult activity? If yes, please explain:

What is your opinion of God?

What is your opinion of Jesus?

What is your opinion of the Holy Spirit?

Do you desire a deeper relationship with God? ☐ Yes ☐ No

Do you attend Bible studies? ☐ Yes ☐ No

Do you pray and read Scripture daily? ☐ Yes ☐ No

RELEASE OF INFORMATION
HHFH Residential Program
HHFH Drop-In Program
HHFH Peer Navigation Program

As part of my application process for any of the programs at His House for Her, Inc. I, _____, hereby authorize any of the entities specified below to release without liability, information regarding my physical, mental health, and psychiatric medical history, substance use history, history of treatment for substance use, employment, income, and/or criminal background.

I understand that this authorization can only be used to obtain information about me that is pertinent to my eligibility for the programs at His House for Her, Inc. Pertinent information includes my physical and mental health medical history, substance use history, history of treatment for substance use, and my ability to pay required program fees.

The following groups or individuals will be contacted as deemed necessary. The groups or individuals that may be contacted include, but are not limited to:

- Any and all Physicians
- Any and all Treatment and Recovery Centers
- Any and all Treatment Providers, Clinicians and Therapists
- Past/Present Employers
- Background Check Providers
- Attorney, Probation and/or Parole Office and Department of Corrections
- Department of Children and Families, Guardian-ad- Litem Program and any case management agencies
- Friends, Personal Contacts, Family Members
- Any and all social service agencies pertinent to my treatment and recovery

CONDITIONS:

I, _____, agree that a photocopy of this authorization may be used for the purposes stated above. The original of this authorization in on file and will stay in effect for a year from the date signed. I understand that I have a right to review this file and correct any information that I can prove is incorrect.

ACKNOWLEDGEMENT:

My signature below signifies that I have read and understand the terms and conditions set forth in this Release of Information.

_____ _____

Signature of Program Participant/Resident Date

CONGRATULATIONS ON YOUR DECISION TO SEEK A FRESH START!

Please read the following statements and initial them if you agree.

_____ I understand that completing this application does not guarantee I will be accepted into the program.

_____ I understand that I may be offered an in-depth interview to adequately determine that His House for Her is able to meet my very important needs.

_____ I understand the information I provide on my application will be verified for accuracy and truth.

_____ I understand His House for Her is a Christ-centered program for adult women desiring healing and wholeness.

_____ I understand His House for Her is a 4–12-month faith-based program with a minimum of 4 months required.

_____ I understand, if approved, I will receive a thorough, trauma-informed assessment and work with the HHFH Care Team to create my own strength-based Individual Recovery Plan.

_____ I understand His House for Her is a smoke free, tobacco free and vape-free campus.

_____ I understand His House for Her will assist me in finding employment to contribute towards my program fees.

_____ I understand His House for Her conducts random 14-panel drug screens and that refusal to submit to a drug or alcohol test and/or dirty or diluted test results may be grounds for immediate dismissal.

_____ I understand possession of any illegal substances and/or drug paraphernalia both on and off His House property may be grounds for immediate dismissal.

_____ I understand not respecting the property of others and stealing both on and off His House property may be grounds for immediate dismissal.

_____ I understand, if I am accepted into the program at His House for Her, I will be required to abide by their rules and house structure which includes but is not limited to: no cell phone possession or use, no social media, limited computer use, limited pre-approved personal telephone calls after initial 30 days, limited pre-approved visitation after 60 days.

_____ I understand weekly church attendance and adherence to the Core Values of kindness, excellence, service, accountability, and unity is required.

_____ I understand, if accepted, I will be screened for drugs and alcohol at the time of move-in. If I screen positive, I understand I am expected to complete detox at a detox facility <u>before</u> I may be admitted to the residence.

I do hereby agree that all the information contained in this application is true, correct, and complete. I understand that any misrepresentation, falsification, or omission of information on this application may result in immediate dismissal from the HHFH program.

_____ _____

Signature of Applicant Date