



Completed application can
be faxed to: 864-231-9874

Haven of Rest Women's Ministry *Under His Wings*

APPLICATION

I. Client's Personal Data:

Name _____ Date _____ Age _____

Date of birth _____

Permanent Address _____ City _____ State _____

Home Phone _____

Emergency Contact Person _____ Phone _____ Relationship _____

Please check all that apply:

Marital status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Race (not required) - White _____ Black _____ Hispanic _____ Asian _____ American Indian _____ Other _____

Religious background _____ Church _____ Are you a member? _____

Pastor's name _____ Phone number _____ May we contact him? _____

Type of problem you have?	Drugs _____	Prescription meds. _____	Alcohol _____	Sex/pornography _____
	Gambling _____	Nicotine _____	Emotional _____	Anger _____
	Spiritual _____	Marriage _____	Other _____	

SUBSTANCE ABUSE HISTORY (CHECK ALL THAT APPLY)

_____ Alcohol	_____ crack	_____ lsd (acid)	_____ ritalin
_____ Amphetamine	_____ Demerol	_____ marijuana	_____ valium
_____ Angel dust	_____ ecstasy	_____ methamphetamine	_____ xanax
_____ Barbiturates	_____ hashish	_____ mushrooms	_____ ativan
_____ caffeine	_____ heroin	_____ nicotine	_____ others
_____ cocaine	_____ hydrocodone	_____ opium	
_____ codone	_____ klonopin	_____ oxycodone	

What is your addiction at this time? _____ How long have you been using? _____

When is the last time you used? _____

Do you smoke? _____ How many packs a day? _____ Are you willing to quit? _____ Do you understand that we are a smoke free facility and that you will not be allowed to smoke while in the program? _____

II. Medical Information

HEALTH HISTORY

_____ Accidents	_____ Hearing voices	_____ Sleeping disorder
_____ Allergies	_____ Heart	_____ Suicide attempts
_____ Blackouts	_____ Hepatitis (type) _____	_____ TB
_____ Cancer	_____ High Blood pressure	_____ Ulcers
_____ Convulsions	_____ HIV	_____ Other
_____ Diabetes	_____ Injuries	_____ Other
_____ DT's	_____ Liver Disease	
_____ Epilepsy	_____ Physical limitations	Do you have any food allergies? _____
_____ Hallucinations	_____ Seizures	If so explain _____
_____ Handicaps	_____ Shakes	_____

What other Medical problems do you have?

ON ALL THAT YOU CHECKED PLEASE WRITE A BRIEF STATEMENT ON BACK ABOUT EACH. (THIS MUST BE COMPLETED BEFORE YOUR APPLICATION WILL BE ACCEPTED)

Do you have any Psychiatric Disorders? ___ Yes ___ No

Diagnosis _____

Have you ever been hospitalized for mental or emotional disorders? _____

Where? _____ Doctors name _____

Name of Family Doctor? _____ Phone # _____

LIST ALL MEDICATIONS AND THE DOCTOR WHO PRESCRIBED THEM (IF NOT SAME DR. AS ABOVE)

Name of medication _____ mg ___ prescribed by _____ times taken daily _____

How long have you been taking? _____

Name of medication _____ mg ___ prescribed by _____ times taken daily _____

How long have you been taking? _____

Name of medication _____ mg ___ prescribed by _____ times taken daily _____

How long have you been taking? _____

IF YOU HAVE MORE THAN THREE, LIST THE OTHERS ON THE BACK OF THIS SHEET.

DO YOU UNDERSTAND THAT UNDER HIS WINGS IS NOT A MEDICAL FACILITY AND THAT NO NARCOTICS, BARBITURATES AND PSYCHOTIC MEDICATION WILL BE ALLOWED? MEDICAL AND DENTAL MATTERS MUST BE TAKEN CARE OF PRIOR TO ADMITTANCE AND THAT IF YOU BECOME ILL ENOUGH TO HAVE TO BE TAKEN TO THE HOSPITAL OR TO THE DOCTOR, YOU MUST LEAVE THE PROGRAM UNTIL YOU ARE WELL AND ABLE TO RETURN? _____

Have you been in treatment before for substance abuse or alcohol? Yes _____ No _____

If yes-Where? _____ Dates _____

Did you finish program? _____ Reason for leaving? _____

Contact person? _____ Phone # _____

May we contact them? _____

2nd treatment facility _____ Dates _____

Did you finish program? _____ Reason for leaving? _____

Contact person _____ Phone # _____ May we contact them? _____

IF THERE ARE ADDITIONAL PROGRAMS, PLEASE ADD TO BACK OF SHEET THE SAME INFO

III. LEGAL INFORMATION

Do you have pending legal obligations? _____ Any hearings? _____

DO YOU UNDERSTAND THAT ALL LEGAL OBLIGATIONS **MUST** BE TAKEN CARE OF BEFORE YOU ENTER UNDER HIS WINGS?

Have you ever been arrested? ___ No ___ Yes – How many times? ___ Last date? _____ Charges _____

Clients entering the program without notifying their probation officers will be subject to dismissal.

- We will not make phone calls to courts or parole officers or provide progress reports.
- If Court/PO contacts us, we are obligated to give them a truthful report of your progress, but we will not contact them for you, YOU MUST TAKE CARE OF THAT BEFORE COMING IN.

Are you on probation? _____ Probation officer's name _____

What were the charges? _____ Are you court ordered to a program? _____

Have you ever been in prison? ___ Yes ___ No Charges _____

Do you understand that you will be required to submit a criminal report prior to admittance to Under His Wings? _____

Requested Donation:

\$100 – Cost of Materials

I UNDERSTAND THAT I AM ENTERING A 6 MONTHS RESIDENTIAL PROGRAM, AND I AM COMMITTED TO SUCCESSFULLY COMPLETING THE PROGRAM. _____ YES _____ INITIAL

I UNDERSTAND THAT I AM SUBMITTING MYSELF TO THE SPIRITUAL GUIDANCE AND AUTHORITY OF THE UNDER HIS WINGS STAFF. _____ YES _____ INITIAL

I UNDERSTAND THAT I WILL BE REQUIRED TO HAVE PREGNANCY, HEP C, HIV AND TB TEST BEFORE ENTERING UNDER HIS WINGS. (YOU CAN GET THESE AT LOCAL HEALTH DEPT. OR FAMILY DOCTOR)
_____ YES _____ INITIAL _____

I UNDERSTAND THAT I WILL BE REQUIRED TO SUBMIT A CRIMINAL REPORT BEFORE ENTERING UNDER HIS WINGS
_____ YES _____ INITIAL _____

I UNDERSTAND THAT IF UNDER HIS WINGS IS MADE AWARE OF ANY OUTSTANDING WARRANTS ON ME THEY HAVE NO CHOICE (BY LAW) BUT TO REPORT IT. _____ YES _____ INITIAL _____

I UNDERSTAND THAT UNDER HIS WINGS IS NOT A MEDICAL FACILITY AND THERE ARE ONLY CERTAIN MEDICATIONS THAT I WILL BE ABLE TO TAKE THERE? _____ YES _____ INITIAL _____

I UNDERSTAND THAT UNDER HIS WINGS IS A CHRISTIAN PROGRAM AND NOT AN AA OR NA PROGRAM. _____ YES
INITIAL _____

I UNDERSTAND THAT I WILL NOT BE ALLOWED TO SMOKE OR USE TOBACCO AT ANY TIME WHILE ENROLLED IN THE PROGRAM. _____ YES _____ INITIAL _____

I UNDERSTAND THAT A \$100.00 DONATION IS REQUESTED UPON ENTRANCE. _____ YES _____ INITIAL _____

I _____ DO DECLARE THAT ALL OF THE ENCLOSED INFORMATION IS TRUE AND THAT I SINCERELY DESIRE A CHANGE IN MY LIFE.

SIGNATURE _____ DATE _____

Return completed Application by one of the following methods:

Fax - 864-231-9874

Email - Theresa.Allen@havenofrest.cc

Mail - Under His Wings
ATTN: Theresa Allen
219 W. Whitner St.
Anderson, SC 29624

STAFF USE ONLY

Was Client accepted? _____ When will she be coming in? _____

If not accepted, give reason _____

If not accepted, were you able to refer her somewhere else? _____

Where? _____