Admittance Application

APPLICATION FOR RESIDENCE AT WOMEN'S CARE CENTER

To be accepted into Women's Care Center an applicant must complete this application. Carefully read and honestly answer all the questions. Living at the Women's Care Center is a privilege, and if you understand its value, it will help you in the maintenance of your sobriety without relapse.

Women's Care Canter does not accept sex offenders or anyone convicted of a violent offense. We currently do not take anyone with an electric monitor. The Center is not a medical treatment facility. The facility does not accept anyone who has been prescribed mood-altering medications.

*** Please Print Clearly**

Date: _____ Social Security No.: _____

Name: _____ Date of Birth: _____

Present Address:

_____

Is this a treatment facility? _____ Phone Number:_____

Are you an alcoholic? _____ Date of Last drink: _____

Are you addicted to drugs: _____ Date of Last use? _____

List of all drugs you have used:

_____

_____

Do you want to stop using drugs and drinking?

_____

Are you willing to participate in the Spiritual program that we offer at Women's Care Center? Including, but not limited to, Daily Devotions, Bible Studies, Church Attendance and 12 Step Meetings?

_____

Are you currently in treatment or incarcerated? _____

If yes, then where and how long?

_____

Do you have any current pending charges? _____

If yes, explain:

_____

_____

List all criminal convictions:

_____

_____
_____
_____

Are you a Registered sex offender? _____

Are you on probation or parole? _____

If yes, then how long, what county?
_____

What is your parole or probation officer's name and phone number?
_____

What is your report schedule?
_____

What types of work can you do?
_____
_____
_____

What are your plans for finding a job?
_____
_____
_____

What is your current monthly income?
_____

What do you expect your income to be in the next month?
_____

What is your marital status? _____

Do you have children? _____

If yes, how many? _____

Do you owe child support? _____ If yes, amount? _____

Past due amount? _____

Have you ever been to a treatment facility for drug or alcohol addiction?
_____

If yes, how many times? _____ When was the last time? _____

Where?_____

Do you have a medical doctor? _____

Present Medical History

Check those questions to which you answer yes (leave the others blank).

- ☐ Has a doctor ever said your blood pressure was too high?
- ☐ Do you every have pain in your chest or heart?
- ☐ Are you often bothered by a thumping of the heart?
- ☐ Does your heart often race?
- ☐ Do you ever notice extra heartbeats or skipped beats?
- ☐ Are your ankles often badly swollen?
- ☐ Do cold hands or feet trouble you even in hot weather?
- ☐ Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- ☐ Do you suffer from frequent cramps in your legs?
- ☐ Do you often have difficulty breathing?
- ☐ Do you get out of breath long before anyone else?
- ☐ Do you sometimes get out of breath when sitting still or sleeping?
- ☐ Has a doctor ever told you your cholesterol level was high?
- ☐ Has a doctor ever told you that you have an abdominal aortic aneurysm?
- ☐ Has a doctor every told you that you have critical aortic stenosis?
- ☐ Are you pregnant?
- ☐ Could you be pregnant?

Comments

_____

_____

_____

_____

Do you now, have, or have you recently experienced:

- ☐ Chronic, recurrent or morning cough?
- ☐ Episodes of coughing up blood?
- ☐ Increased anxiety or depression?
- ☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
- ☐ Migraine or recurrent headaches?
- ☐ Swollen or painful knees or ankles?
- ☐ Swollen, stiff or painful joints?
- ☐ Pain in your legs after walking short distances?
- ☐ Foot problems?
- ☐ Back problems?
- ☐ Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhea?
- ☐ Significant vision or hearing problems?
    - ☐ Recent change to a wart or mole?
    - ☐ Glaucoma or increased pressure in the eyes?
    - ☐ Exposure to loud noises for long periods?
    - ☐ An infection such as pneumonia accompanied by a fever?
    - ☐ Significant unexplained weight loss?

- □ A fever, which can cause dehydration and rapid heartbeat?
- □ A deep vein thrombosis (blood clot)?
- □ A hernia that is causing symptoms?
- □ Foot or ankle sores that won't heal?
- □ Persistent pain or problems walking after you have fallen?
- □ Eye conditions such as bleeding in the retina or detached retina?
- □ Cataracts or lens transplant?
- □ Laser treatment or other eye surgery?

Comments_____

_____

List any prescription medications you are now taking:

_____

_____

_____

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:

_____

_____

Date of last complete physical examination: _____

□ Normal □ Abnormal □ Never □ Can't remember

Date of last pap smear and mammogram? _____

□ Normal □ Abnormal □ Never □ Can't Remember

Date of your last tetanus shot? _____

Date of last chest x-ray: _____

□ Normal □ Abnormal □ Never □ Can't Remember

Date of last electrocardiogram (EKG or ECG): _____

□ Normal □ Abnormal □ Never □ Can't Remember

Date of last dental check-up: _____

□ Normal □ Abnormal □ Never □ Can't Remember

List any other medical or diagnostic test you have had in the past two years:

_____

List hospitalization, including dates of and reasons for hospitalization:

_____

_____

List of any drug allergies_____

_____

_____

Past/Current Medical History

Check those questions to which your answer is yes (leave others blank).

- ☐ Heart attack if so, how many years ago? _____
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Diseases of the arteries
- ☐ Varicose veins
- ☐ Arthritis of legs or arms
- ☐ Diabetes or abnormal blood-sugar tests
- ☐ Phlebitis (inflammation of the veins)
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Diphtheria
- ☐ Scarlet Fever
- ☐ Infectious mononucleosis
- ☐ Nervous or emotional problems
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Current STD
- ☐ Hepatitis A, B, or C
- ☐ HIV +
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Abnormal chest X-ray
- ☐ Other lung disease
- ☐ Injuries to back, arms, legs, or joints
- ☐ Broken bones
- ☐ Jaundice or gall bladder problems
- ☐ Tuberculosis

Comments_____

_____

Do you have mental illness? _____

If yes, please explain:

_____

_____

_____

Do you take prescription or psychotropic drugs? _____

If yes, list all medications you take and the reason you take them:

_____

_____

_____

Date you would like to enter Women's Care Center: _____

Do you have a valid driver's license? _____Birth Certificate? _____

Do you have a Social Security Card? _____ Photo Id? _____

List 3 Emergency Contacts: **NAME** **NUMBER**
RELATIONSHIP

1. _____
   _____
2. _____
   _____
3. _____
   _____

List anything additional you would like to share:

_____

_____

_____

Medical Record Information

Date: _____

Last Name: _____ First Name: _____

Emergency Contact Name:

_____

Emergency Contact Number:

_____

Medical Doctor's name: _____Number: _____

Address:

_____

Are you currently taking any prescription medication?

_____

If yes, list all medications, size (milligrams) and dosage frequency (how often).

Medication: Size (mg/mcg) Dosage Frequency:

_____

_____

_____

_____

Have you ever attempted suicide? (If so, when/disposition):

_____

Did you seek psychiatric help?

_____

_____

List of any special medical requirements you have or need:

_____

_____

_____

_____

Do you have any known allergies? _____ If yes, then list:

_____

With my signature, I hereby declare that Main Street Ministries and Women's Care Center is not responsible for any injury, medical condition or self-inflicted injury during my stay.

It is also my understanding that *drug test and breath analysis will be conducted on a random basis*, during house meetings and after returning from day and overnight passes or if the Women's Care Center Manager or staff deems it necessary due to erratic, suspicious or unusual behavior.

By signing this document, I am giving my consent to be tested by Women's Care Center staff, by way of urinalysis and breath analysis, for the use of drugs and alcohol.

I also understand that if any drug test administered to me turns out positive, I will be referred to the Executive Director, and will be immediately expelled from Women's Care Center.

Secondary knowledge: I also understand that if I find out that one of my house mates is using drugs (other than those prescribed for her) or alcohol, and I don't say anything, and it is proven that I was aware of it, I too will be referred to the Executive Director, and could be expelled from Women's' Care Center.

I hereby declare that information provided by me about my medical history and condition is accurate. I understand any untruthful statement or information is grounds for immediate dismissal from the program.

_____

Resident's Signature

Date_____

_____

Women's Care Center Manager

Date_____

Essay

Please use the following pages to write an essay on why we should accept you into Women's Care Center. Why do you think you are ready to change and how do you plan to implement that change? List at least 5 goals for the next 6 months.

I have read all the material on this form. I have answered each question honestly and want to achieve comfortable recovery from alcoholism and/or drug addiction without relapse.

Signature: _____ Date: _____

WOMEN'S CARE CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This document fulfills all state and federal regulations to the Texas Civil Rights Practice and Remedies Code (Section 74.052); the Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Part 160 and 164); and the federal and state laws pertain to and commonly referred to as "HIPPA," and any and all other acts cited below. **AUTHORIZATION FOR DISCLOSURE RELEASE INFORMATION/MEDICAL RECORDS**

Health Insurance Portability and Accountability Act of 1996
45 CFR Subtitle A, Subchapter C, Part 164.512 € (1) (iii)

NAME: _____ SOCIAL SECURITY NO: _____

DATE OF BIRTH: _____

Date of service/treatment to be received/released: _____to date of final disposition.

CLASS OF PERSONS AUTHORIZED TO MAKE THE DISCLOSURE:

All physicians and other health care providers who have examined, treated, consulted with, or x-rayed _____ and all hospitals, nursing facilities, rehabilitation facilities, clinic or laboratories in which I have been and/or currently a patient and/or resident.

DESCRIPTION OF INFORMATION TO BE DISCLOSED:
You are hereby authorized and directed by the undersigned to give to the bearer of this authorization, or any photo static copy thereof, any and all information relative to _____'s physical, emotional, and mental condition and permit the bearer to examine x-rays, laboratory reports, and medical records of any kin of which reflects diagnosis, treatment, prognosis, and any other information concerning illness, injuries, or disability. Such information shall specifically include, but is not limited to, itemized billing records/statements, history & physical, operative reports, lab/pathology reports, consultation reports, physicians' orders, discharge/death summary, x-ray reports/images, other radiographic reports/images, emergency room records, face sheets, nurses' notes, flow sheets, pharmacy and medication records, care plans, assessment tools, screening tools, summaries, social workers, legal, and monitor strips, readouts or printouts. I understand that the specified information to be received/released may include, but is not limited to: history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, psychological and/or psychiatric treatment, counseling records/note, genetic testing or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). You are hereby authorized and directed to make available all such information for inspection and coping.

DURATION OF THIS AUTHORIZATION:
This authorization expires one (1) year for the date signed.

RIGHT TO REVOKE:
I understand that I may revoke this authorization in writing at any time by contacting Women's Care Center, except to the extent that action has been taken in reliance upon the authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected.

I understand that I have a right to a copy of this authorization.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances, such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

A photo static copy of this authorization shall be considered as valid as the original.

This authorization applies to Women's Care Center, as the releaser/receiving institution and recipient of all records and information contained in this notice.

_____ _____

DATE SIGNED **PRINT NAMED PERSON LEGALLY AUTHORIZED TO MAKE RELEASE**

_____

SIGNATURE OF PERSON LEGALLY AUTHORIZED TO MAKE RELEASE

Women's Care Center Release Agreement

The undersigned enters into this agreement with Women's Care Center. I have been informed and understand that Women's Care Center wishes to use photographic images of myself in its printed materials, video programs and website.

1. I grant Women's Care Center and its designees the right to use such images. This grant includes the right to edit, mix or duplicate and to use or re-use the images in whole or in part and in any manner as Women's Care Center in its sole discretion may elect. Women's Care Center or its designee shall have complete ownership of the images and any printed material, video programs and web content (i.e., material accessible over the internet) in which the images may appear.
2. I also grant the right to broadcast, exhibit, market, sell, and otherwise distribute images as well as printed materials, video programs and/or web content, wither in whole or in part, and either alone or with other products.
3. I confirm that I have the right to enter into this Agreement; that I am not restricted by any other commitments to third parties; that Women's Care Center has no financial commitment or obligations to me as a result of this agreement.
4. I hereby give all clearances, copyright and otherwise, for the use of such images, and I expressly release Women's Care Center and its officers, employees, agents and designees from any and all claims known or unknown arising out of or in any way connected with the above uses and representations.
5. The rights granted to Women's Care Center herein is perpetual. I hereby acknowledge receipt of reasonable and fair consideration.

Date: _____

Resident Name (Please Print): _____

Resident Signature: _____

Women's Care Center Manager Signature:

_____

WOMEN'S CARE CENTER

Liability Release Form

Release of All Claims

In consideration of being accepted by Main Street Ministries for participating in any and all activities including work or work related events, we being 18 years of age or older, do for ourselves hereby release, forever discharge and agree to hold harmless First Baptist Church Vidor and Main Street Ministries, and its officers, directors, members, agents, servants, and employees from any and all liability, claims, or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned.

Furthermore, we for ourselves hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in the Women's Care Center program and all activities associated with said program.

The undersigned further hereby agree to hold harmless and indemnity First Baptist Church Vidor and Main Street Ministries, its officers, directors, members, agents, servants, and employees for any liability sustained by First Baptist Church Vidor and Main Street Ministries, as the result of the negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

The use of plurals such as "we, ourselves," etc., is intended to also encompass the singular and should be read as "myself" etc., where appropriate.

_____ _____

Residents Signature **Date**

_____ _____

Women's Care Center Manager **Date**

WOMEN'S CARE CENTER

FINANCIAL AGREEMENT FORM

Date: _____

Name: _____

This letter is to inform you of the financial responsibilities that you must follow in order to stay at Women's Care Center.

Deposit	**$500.00**
First Month's Rent	**$400.00**
TOTAL MOVE-IN AMOUNT	**$900.00**

After the move-in payment, program fees will be collected on a weekly or monthly basis, by the Women's Care Center Manager, no later than 7:00pm each Friday, or by 7:00pm on the 1st of each month if paying monthly.

The program fee will be $400.00 monthly or $100.00 weekly. This must be paid in the form of cash or money order made payable to **Main Street Ministries.**

If the program payment is late, there will be a late charge of up to $25.00 if paying by the week or $50.00 if paying by the month. If the program fee is not paid within 7 days of the due date the resident could face possible termination from the program.

I hereby understand that my deposit can be used or forfeited due to the following reasons:

- Voluntary or involuntary departure for the program, for any reason prior to graduation.
- Payment of medical co-pay fees or medical treatment required.
- Destruction of property; whether Main Street Ministries, cooperating churches or other participants/residents.

I hereby understand that any balance of the deposit is refundable at graduation or re-entry.

With my signature, I agree to all rules and regulations specified on this form.

_____ _____

Resident Signature **Printed Name**

AUTHORIZATION TO HOLD, AND SECURE RESIDENT'S MEDICATION

RESIDENT'S NAME: _____

Let it be known that I, _____, do hereby give unto Women's Care Center the right to hold and possess under a safe and secure method all my prescription medications duly prescribed by a licensed practitioner and/or facility, and filled by a duly licensed pharmacist. This right includes the right to possess and hold all my over-the-counter medications and vitamins. I do hereby release and hold harmless Women's Care Center, its staff, employees, and volunteers regarding the administration of all such medications. I understand that all my medications will be locked in a facility safe and made available at the required times, at the required dosages, and under the required methods of my prescribing physician and/or facility. I do hereby agree not to possess any prescribed medications and/or over-the-counter medication and shall surrender any medications unto Women's Care Center for security and safety of such medications. I further understand that it is my responsibility to have any and all medications refilled. I understand that it is my responsibility to cover the cost of all such medications. Women's Care Center, its staff, employees, and volunteers do not need to hold a medication administration license since these medications are filled prescriptions or over-the-counter medications and vitamins. The ability to change the type, dosage, and administration requirements of my medication is under the direction of my prescribing physician and/or facility and I understand that Women's Care Center, its staff, employees, and volunteers cannot make such changes without a written order from my prescribing physician and/or facility, or a new prescription being filled and distributed by a duly licensed pharmacist.

Witness my hand this the _____day of _____20___.

_____

Resident's Signature

_____

Women's Care Center Manager