Changed Lives Ministry (Women's)

Student Application (Please neatly print all requested information.)

Full Name_____ Date_____

Name you like to be called _____

Address_____

City_____ State_____ Zip_____

Phone (_____)_____ Additional Contact Number (_____)_____

Date of Birth_____/_____/_____(month/day/ year) Age_____Height_____Weight _____

Can you read well?........... not well_____

Social Security Number_____/_____/_____

Valid Driver's License Number _____ State_____

Single_____Married_____Separated_____Widowed_____Divorced_____Engaged_____

If Married, Spouse's Name _____

Children?_____Names and Ages_____

_____

Emergency Contact_____Phone (_____)_____

Addiction and Medical Issues

List the substances to which you're addicted:

_____

_____

List other medications you are currently taking:

_____

_____

List all medical conditions (bi-polar, handicapped, schizophrenia, etc.):

_____

Have you ever had convulsions, seizures, or blackouts?   Yes_____No_____

List any allergies   _____

Do you have heart disease, diabetes, epilepsy, respiratory disease, etc.? Yes_____No_____

Do you have a Naltrexone Implant?   Yes_____No_____

Do you have a doctor?   Yes____No____Name/Number_____

Do you have medical insurance?   Yes____No____

Insurance Company_____

Phone (_____)_____   Fax(_____)_____

Policy Number_____

Sign here to give permission to Changed Lives Ministry to consult with your doctor, insurance company, or health department about your medical situation:

Sign:_____Date_____

Legal Issues

List all pending court dates, jail terms, Charges, etc.:

_____

_____

Are you ordered by the court to enroll in this program? _____

Are you under bond?_____   County/State_____

Do you have a Probation Officer?_____Name/Number_____

Do you have an Attorney?_____Name/Number _____

Sign here to authorize Changed Lives Ministry to a background check, consult with your Probation Officer and/or your attorney regarding your legal situations:

Sign your name_____   Date_____

For Office Use Only

Probation Officer Consulted?_____Date:_____/_____/_____

Probation Officer's Name/Number_____

Notes:_____

Attorney Consulted?_____Date:_____/_____/_____

Attorney's Name/Number_____

Notes: _____

_____

Manager/Director Signature:_____Date_____

Student's Name_____

Changed Lives Ministry
<u>Sponsor's Responsibilities</u>

1. Assuring the resident has the necessary blood tests faxed to us.
2. Assuring the resident has transportation to and from CLM facility. If a situation arises that a resident <u>cannot</u> or <u>does not</u> desire to complete the program, the sponsor is responsible for picking that individual up **promptly upon departure.**
3. Assuring the three hundred and twenty-five dollar ($325) medical deposit upon entrance. This is for the resident's use should they require medical assistance while in the program. **A non-refundable processing fee of $25 will be deducted.** At no time during the resident's stay is the medical deposit to be used for anything other than medical expenses.
4. Assuring no alcohol or drugs are in the resident's belongings upon arrival.
5. Assuring that the resident has all needed items such as clothing, toiletries, etc. (No toiletries, cosmetics, etc. <u>containing alcohol content</u> are allowed.)
6. Assuring that the resident brings any proper/necessary prescription medications needed for the duration of time in the program.
7. The resident will be drug/alcohol tested upon arrival. A positive test result will terminate any current admissions agreement and the resident will not be permitted to remain at the CLM facility at that time. Should this occur, it is the responsibility of the sponsor to provide transportation from the CLM facility. The resident may be rescheduled to come in at a later date.

<u>SPONSORS AGREEMENT:</u>
"I take responsibility for all of the above as this resident's sponsor".

Residents Name: .
Sponsors Name: .
Address: .
Telephone Number: .
Signature: Date: .

Pre-Admission Blood Test Report

This form is to be submitted to your health care provider (doctor, clinic or Health Department), then faxed directly to Changed Lives Ministry by your provider.

_____has applied for entrance into Changed Lives Ministry for a ten-week drug and alcohol rehabilitation program.

Blood Tests for the following are required for admissions into our program:

TEST RESULTS/COMMENTS/RECOMMENDATIONS

_____

HIV

_____

STD/RPR

_____

PPD

_____

HEPATITIS C

_____

Flu Shot

_____

Pregnancy Test

_____

Please complete in full, then fax directly, with your agency's cover sheet, to
Changed Lives Ministry @ FAX (843) 899-4012

Thank you,

Keith Griggs, Director
CHANGED LIVES MINISTRY

Phone: (843) 899-4011
FAX: (843) 899-4012