



Application, Admittance, & Releases

NOTICE: I understand that by filling out this application and presenting it for admittance to this program, I authorize the Salvation Army Adult Rehabilitation Center to contact law enforcement agencies to see if I have any warrants for my arrest, violent crimes, and sexual crimes offenses. I also understand that by virtue of this contact, law enforcement agencies will know I am here.

I acknowledge that the Salvation Army Adult Rehabilitation Center will check all local, county, state, and national crime databases for any and all crime convictions and outstanding warrants.

Misrepresentation of the information requested on this form, convictions disclosed on this form, or a confirmed listing on a state's sex offender website shall result in denial of admission as a beneficiary to the Salvation Army Adult Rehabilitation Center.

I have read and understand the foregoing contents. I acknowledge that my signing of this consent and release is a voluntary act on my part. I release the Salvation Army and its affiliated entities for any liability arising out of information acquired on local, county, state, or national crime databases or from its communications with law enforcement agencies in this regard.

Name (Printed Name): _____

Signature: _____ Date: _____

Witness: _____

Signature: _____ Date: _____

If you have warrants, you will not be admitted to this program.



Welcome to the Salvation Army Adult Rehabilitation Center. For your protection and ours **before being admitted to our program you must have the following:**

- Driver’s license, state identification card, social security card, or positive identification with your social security number on it.
- Shelter clearance ID card (not the blue paper) or proof that you recently had a T.B. (tuberculosis) test done.
- A 30-day supply of any medication you are prescribed by a doctor.

If you do not have all the above items we will not be able to admit you to the program.

If you have all of the above items, please answer the following questions:

Have you ever been to a Salvation Army Adult Rehabilitation Center? Yes No
If so, Where? _____ When? _____

Do you have any conditions that will prevent you from standing or lifting for long periods of time? Yes No

Are you under a doctor’s care at this time? Yes No

Do you have any appointments or court dates within the next 30 days? Yes No
If so, Where? _____ When? _____

Are you on parole or probation? Yes No

I understand that if I have not answered the above questions truthfully, this will be grounds for immediate dismissal from the Salvation Army Adult Rehabilitation Center program if I am admitted.

Signature: _____ Date: _____



30-Day Restriction Agreement

I understand that upon admittance to the Salvation Army Adult Rehabilitation Center, I will not be able to use the phone, leave the property, or have any visitors for the first 30 days for **ANY REASON**.

- I have a thirty day supply of my medications. Y or N Initial _____
- I am currently not on any medications. Y or N Initial _____
- I do not have any appointments for the next 30 days. Y or N Initial _____

Signature: _____ Date: _____

Witness: _____ Date: _____

I agree to the following:

1. Attend all required religious services, Bible studies, and substance abuse meetings.
2. Adhere to all house rules and guidelines set for conduct.
3. Completed all paperwork and assignments.

If you agree to these conditions and wish to be part of our six month program, then please sign below.

Signature: _____ Date: _____

Witness: _____ Date: _____



**DOING
THE MOST
GOODSM**

The Salvation Army Adult Rehabilitation Center
2041 NW 7th St., Oklahoma City, OK 73106
405.236.3677 office 405.232.5841 fax
www.salvationarmyarcokc.org

Beneficiary Application for Admission

Name _____ Admission Date: _____
Last First Middle

Driver's License No. & State (if any) _____ Type of License: _____

Expiration Date: _____ Birthplace: _____ Date of Birth: _____

Age: _____ Weight: _____ Height: _____ Complexion: _____ Eyes: _____ Hair: _____

Social Security No. _____ - _____ - _____ Member of Union: _____ Member of Vet. Org. _____

What benefits are you now receiving? _____ Social Security: _____
Amount

General Assistance: _____ Other Income: _____
Amount Amount

Number of weeks in City _____ Last Residence: _____

Have you ever been arrested due to alcohol? _____ Disorderly? _____

Military Service: Total number of years _____ Branch(s) _____

Service Number: _____ Type of Discharge: _____

Education & Training: (Circle Grades Completed)

<u>1 2 3 4 5 6</u>	<u>7 8 9</u>	<u>10 11 12</u>	<u>1 2 3 4</u>
Elementary School	Jr. High	High School	College

<u>1 2 3 4</u>	
Trade, Specialty, Apprenticeship	Name of School

Religious preference (if any): Protestant _____ Denomination? _____ Catholic _____

Orthodox _____ Jewish _____ Other _____ None _____ Have you accepted Christ as your Savior? _____

Occupation best qualified for by training and experience: _____ Years experience: _____

Left Last Job: _____ Type of work done: _____

Last Employer: _____
Name of Company Address City & State

Other occupations in the recent years: _____

Health: Good _____ Fair _____ Poor _____ I will need attention: _____

Condition(s) probably needing medical attention: _____

Will you submit to a physical examination?: _____

Family: Give address or indicate if deceased:

(Check the box at the end if you do not want them to know your whereabouts.)

Mother: _____ Birthplace: _____

Father: _____ Birthplace: _____

Sister: _____ Brother: _____

Wife: _____ Birthplace: _____

Married: _____ Separated: _____ Divorced: _____ Widowed: _____

In case of Emergency, next of kin to notify: _____

Relationship to You: _____ Telephone: _____

Their Address: _____
Street City State Zip

Have you ever been in prison? _____ Where: _____

Are you on parole now? _____ State: _____ Federal: _____ County: _____

Crime convicted of _____ Time Served: _____ Where: _____

REFERRED BY WHOM? _____

The problem(s) I seek help for:

Drinking _____ Other Addiction _____ Health _____ Religious _____
Employment _____ Family _____ Nomadism _____ Sex _____ Other _____

The help I have sought to date with the problem(s):

Religious Counseling _____ Salvation Army Centers _____ Goodwill _____ Half-way houses _____
Hospitalization _____ Psychological _____ A.A. _____ Antiabuse _____ Employment Services _____
Tranquilizers _____ Other _____

SALVATION ARMY CENTERS TO WHICH YOU HAVE BEEN ADMITTED

1. Center _____ From _____ To _____ Reason Left _____
2. Center _____ From _____ To _____ Reason Left _____
3. Center _____ From _____ To _____ Reason Left _____
4. Center _____ From _____ To _____ Reason Left _____

How did you learn of this Center? _____

How long are you planning to stay? _____

Applicant's Signature: _____

Medical Information Confidential

Administration (page 1 of 2)

CONFIDENTIAL

Section A.

A-1. First Name _____

A-2. Last Name _____

Section B. *Directions:* Please choose if you have any of these conditions now or within the past (6) months.

B-1. Choose Below:

- | | | |
|---|--|---|
| <input type="checkbox"/> Severe Aches | <input type="checkbox"/> Severe pains | <input type="checkbox"/> Back pains |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> TB- Tuberculosis | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Too tired to eat or bathe yourself | <input type="checkbox"/> Bodily Disability | <input type="checkbox"/> Bodily Deformity |
| <input type="checkbox"/> Confined to bed by an illness | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Serious Accident or Injury |
| <input type="checkbox"/> Severe itching or rashes | <input type="checkbox"/> Extreme tiredness even after rest | <input type="checkbox"/> Open wounds that tend not to heal |
| <input type="checkbox"/> Blood while urinating | <input type="checkbox"/> Jaundice (yellow eyes or skin) | <input type="checkbox"/> Severe pains in arms or legs |
| <input type="checkbox"/> Swollen or stiff joints | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Operation | <input type="checkbox"/> Frequent Illnesses | <input type="checkbox"/> Rheumatism (Arthritis) |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> A Chronic Disease | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Water Retention | <input type="checkbox"/> HIV/Aids |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Trauma Survivor/ PTSD | <input type="checkbox"/> Boils |
| <input type="checkbox"/> Extreme tiredness | <input type="checkbox"/> Knocked Unconscious | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Alcohol Misuse | <input type="checkbox"/> Stiff muscles and joints | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Bipolar Disorder (Manic Depression) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Fainting Spells (more that 2x in life) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Drug Misuse | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> High Blood Pressure | | |

B-2. Other:

Medical Information Confidential

Administration (page 2 of 2)

CONFIDENTIAL

B-3. How do any of the above conditions affect your life?

B-4. How do any of the above conditions affect your ability to work?

B-5. Beneficiary Date of Birth

____/____/____

B-6. Age:

B-7. Weight: _____ lbs.

Signature: _____

name

B-8. Beneficiary Date:

____/____/____

Signature: _____

Staff Name

B-9. Staff Date:

____/____/____