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: ________________
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: __________________________

General Assistance: __________________________ Other Income: __________________________

                   Amount                   Amount

Number of weeks in City __________________________ Last Residence: __________________________

Have you ever been arrested due to alcohol? __________ Orderly? __________

Military Service: Total number of years __________ Branch(s) __________________________

Service Number: ______________ Type of Discharge: ________________________________

Education & Training: ____________________________ (Circle Grades Completed)

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<td>Elementary</td>
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<td>Trade, Specialty, Apprenticeship</td>
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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: __________ Federals: __________ 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: __________________________________________________________________________
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:

- □ Severe Aches
- □ Hernia
- □ TB- Tuberculosis
- □ Kidney Problems
- □ Too tired to eat or bathe yourself
- □ Confined to bed by an illness
- □ Hepatitis
- □ Severe itching or rashes
- □ Blood while urinating
- □ Swollen or stiff joints
- □ Operation
- □ Kidney Stones
- □ Allergies
- □ Anxiety
- □ Extreme tiredness
- □ Alcohol Misuse
- □ Varicose Veins
- □ Anemia
- □ Depression
- □ High Blood Pressure

- □ Severe pains
- □ Epilepsy
- □ Heart Trouble
- □ Bladder Infections
- □ Bodily Disability
- □ Schizophrenia
- □ Diabetes
- □ Extreme tiredness even after rest
- □ Jaundice (yellow eyes or skin)
- □ Sexually Transmitted Disease
- □ Frequent Illnesses
- □ A Chronic Disease
- □ Water Retention
- □ Trauma Survivor/ PTSD
- □ Dizzy Spells
- □ Drug Misuse

- □ Back pains
- □ Seizures
- □ Liver Problems
- □ Bladder Problems
- □ Bodily Deformity
- □ Cancer
- □ Serious Accident or Injury
- □ Open wounds that tend not to heal
- □ Severe pains in arms or legs
- □ Tumor
- □ Rheumatism (Arthritis)
- □ Suicide Attempt
- □ HIV/AIDS
- □ Boils
- □ Venereal Disease
- □ Arthritis
- □ Bipolar Disorder (Manic Depression)
- □ Fainting Spells (more that 2x in life)
- □ Hemorrhoids

B-2. Other:
_____________________________________________________________________________________________
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:
_____/_____/_____