Women of Hope

"A Regeneration Facility for Women"

2263 Lower River Road, NW * Charleston, TN 37310
TEL: 423-336-5364 *
email: thehopehouse@yahoo.com

Thank you for your interest in Women of Hope! Attached you will find the preliminary information needed to begin the application process. Please fill out all information and fax or mail to:

Attn: Constance Herring, Administrator
Women of Hope
2263 Lower River Road, NW
Charleston, TN 37310
FAX: 706-243-4803

Upon receipt your application will be reviewed to determine your eligibility. If eligibility is determined you will be sent the Interview Packet to fill out and return. If feasible you may have someone pick up the Interview Packet for you. Upon the return of that information you will be contacted to schedule an interview to consider your acceptance in the program.

Thank you for considering! If you have any questions please feel free to contact me.

In His Service,

Constance Herring, Administrator

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APPLICATION

FULL NAME: _____ AGE: _____ DOB: _____

CURRENT ADDRESS: _____
_____
_____

MARITAL STATUS: [ ] MARRIED How Long? _____ [ ] SEPARATED How Long? _____
[ ] BOYFRIEND How Long? _____ [ ] SINGLE [ ] DIVORCED [ ] WIDOWED
CHILDREN (NAME/AGES):
_____
_____
HOUSEHOLD: [ ] LIVE ALONE [ ] LIVE WITH PARENT/OTHER FAMILY [ ] LIVE WITH ROOMATE(S)/OTHER
[ ] LIVE WITH PARTNER AND/OR CHILDREN [ ] HOMELESS [ ] INCARCERATED

WILL FAMILY OR OTHER(S) PARTICIPATE IN YOUR COUNSELING [ ] YES [ ] NO
IF SO, WHO WILL PARTICIPATE?
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____

PROFESSION/TYPE(S) OF WORK IN THE PAST: _____
YEARS IN CURRENT FIELD OF WORK: _____YEARS IN OTHER FIELDS: _____ YRS FORMAL EDUCATION: _____
WORK/EDUCATIONGOALS:_____

MEDICAL AND OTHER INFORMATION

PLEASE LIST ANY MEDICAL PROBLEM(S) YOU ARE CURRENTLY BEING TREATED FOR:
_____

MEDICATION(S) YOU TAKE: _____

PERSON TO CONTACT IN CASE OF A MEDICAL OR OTHER EMERGENCY:
NAME: _____ RELATIONSHIP: _____
ADDRESS: _____
PHONE: _____

LEGAL HISTORY

CURRENTLY INCARCERATED AT: _____
INTAKE DATE: _____ REASON FOR INCARCERATION (CHARGES): _____
_____
COURT DATE: _____ PROBATION/PAROLE OFFICER:
_____ PHONE: _____
OTHER PAST LEGAL ISSUES/CHARGES:_____
_____
STATUS OF CURRENT/PAST LEGAL ISSUES: (INCLUDING CIVIL CASES, DIVORCE, SEPARATION, CHILD CUSTODY ISSUES): _____
_____

SUBSTANCE ABUSE HISTORY

	AGE FIRST USE	PATTERN OF USE	FREQUENCY OF USE	ROUTE OF ADMIN ISTRATION	DATE OF LAST USE	CURRENT USE YES/NO
Alcohol						
Amphetamine						
Methamphetamine						
Cocaine/crack						
Heroin						
Other IV Drugs						
Hallucinogens						
Cannabis/THC						
Methadone						
Barbiturates						
Inhalants						
Steroids						
Nicotine						
Caffeine						
Other RX Meds						
Other						

DRUG(S) OF CHOICE: _____ MOST FREQUENT TIME OF USE: _____
MORNING USE? [ ]YES [ ]NO USE TO RELAX OR HELP SLEEP: [ ]YES[ ] NO USE TO RELIEVE PAIN/DISCOMFORT /FEEL BETTER? [ ]YES[ ] NO MOST FREQUENT SETTING FOR USE (TIME/PLACE/PEOPLE):_____
BRIEFLY LIST EXPERIENCES OF DT'S?_____
TOLERANCE? [ ] YES [ ] NO WITHDRAWAL? [ ] YES [ ] NO BLACKOUTS/MEMORY LOSS? [ ] YES [ ] NO
VOCATIONAL/EDUCATION/FAMILIAL/LEGAL/ECONOMICAL CHANGES RELATED TO USE? _____
_____
PERIOD OF VOLUNTARY ABSTINENCE: LONGEST: _____ LAST: _____
FAMILY HISTORY OF SUBSTANCE ABUSE (WHICH MEMBERS): _____
_____
HAVE YOU ATTENDED AA/NA (WHEN)? _____ WILLING TO WORK WITH A SPONSOR?: [ ] YES [ ] NO
CURRENTLY ATTENDING AA/NA? [ ] YES [ ] NO HOW OFTEN? _____
HAVE AN AA/NA SPONSOR [ ] YES [ ] NO HOME GROUP? [ ] YES [ ] NO
DO YOU THINK YOUR DRINKING/DRUG USE IS A PROBLEM (IF SO, WHY)? _____
_____
OTHER CURRENT/PAST COMPLUSIVE/ADDICTIVE BEHAVIORS (GAMBLING, EATING, SEX, WORK, NICOTINE, ETC.)_____

COUNSELING/TREATMENT INFORMATION

HAVE YOU BEEN IN TREATMENT, COUNSELING, MENTAL HEALTH TREATMENT BEFORE? [ ] YES [ ]NO
IF SO, PLEASE GIVE US THE FOLLOWING INFORMATION:

FACILITY OR COUNSELOR	PURPOSE ISSUES	WHEN & HOW LONG	RESULTS

WERE YOU PRESCRIBED ANY MEDICATIONS DURING THE TREATMENT PROCESS? [ ] YES [ ] NO
IF SO, LIST MEDICATIONS PRESCRIBED AND DOSAGE: _____
_____
ARE YOU CURRENTLY ON ANY MEDICATIONS? [ ] YES [ ] NO IF SO, LIST ALL CURRENT MEDICATIONS, DOSAGE, WHO PRESCRIBED, WHEN PRESCRIBED, WHY:_____
WHAT ARE YOUR GOALS FOR THE OUTCOME OF COUNSELING? PLEASE DESCRIBE HOW YOU HOPE YOUR LIFE WILL BE DIFFERENT: _____
_____

FAMILY MENTAL HEALTH TREATMENT HISTORY

FAMILY MEMBER	DATE	PROBLEM/DIAGNOSIS	OUTCOME

HAVE YOU OR DO YOU HAVE ANY SUICIDAL IDEATION? [ ] CURRENT IDEATION [ ] PAST IDEATION

IF SO, WHEN? _____ DESCRIBE THE CIRCUMSTANCES SURROUNDING YOUR SUICIDAL IDEATION (THOUGHTS):
_____

WILL YOU BE WILLING TO CONTRACT AGAINST SELF-HARM? [ ] YES [ ] NO

SOCIAL HISTORY/ISSUES/SPIRITUALITY

CURRENTLY SEXUALLY ACTIVE? [ ] YES [ ] NO
AGE OF FIRST SEXUAL EXPERIENCE? _____ CONSENSUAL? [ ] YES [ ] NO
SEXUAL ISSUES/PROBLEMS: _____

SPIRITUAL FAITH GROUP, IF ANY (I.E. BAPTIST, METHODIST, ETC.): _____
ACTIVE IN RELIGIOUS/SPIRITUAL ACTIVITIES? [ ] YES [ ] NO DO YOU BELIEVE IN GOD? [ ] YES [ ] NO

DO YOU HAVE A RELATIONSHIP WITH GOD? [ ] YES [ ] NO SPIRITUAL ISSUES OR PROBLEMS?:

_____
_____

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Authorization for Release of Information

Name: _____ SS#: _____ DOB: _____

I, _____ do hereby request and authorize:
(Print your name)

Women of Hope

2263 Lower River Road, NW

Charleston, TN 37310

to obtain and release to/from;

_____
(Name of person or agency holding information)

_____

_____

_____

the following types of information from my records (and my specific portion thereof): assessments (including physician assessments), social history, diagnoses, treatment plans, medical information, psychological testing reports, progress notes, consultation reports, and information regarding session attendance and compliance with treatment. This information is released for the purpose of: telephone consultations, assessment, treatment planning, and case disposition.

All information I hereby authorize to be obtained from this person or agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for the period necessary to complete all transactions on accounts related to services provided to me, unless I specify an earlier expiration date.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

_____ _____
Signature Date

_____ _____
Staff Signature Date

PLEASE RETURN THIS APPLICATION ALONG WITH A ONE-PAGE SUMMARY OF WHY IT IS IMPORTANT TO YOU TO RECEIVE REHABILITATIVE SUBSTANCE ABUSE TREATMENT AT THIS TIME. WE WILL BE HAPPY TO CONSIDER YOUR REQUEST UPON RECEIPT OF THIS INFORMATION.

FEE SCHEDULE

INTAKE PROCESS FEE: $100.00 (DUE ALONG WITH APPLICATION)

$150.00 PER WEEK (First months fee due upon entrance)

FEES NOT INCLUDED IN TREATMENT FEE:

DRUG SCREEN $10.00 & BREATHALYZER $5.00 EACH

IN ORDER TO BE PLACED IN THIS PROGRAM YOU MUST TRY TO HAVE A SPONSOR ABLE TO PAY YOUR TREATMENT FEES UNTIL YOU REACH EMPLOYMENT PHASE (APPROXIMATELY 3 MONTHS).

PLEASE HAVE YOUR SPONSOR TO FILL OUT THE ATTACHED PROMISSORY NOTE.

INITIAL

_____ I HAVE READ THE RESIDENT HANDBOOK AND AGREE TO ALL POLICIES.

_____ II UNDERSTAND ALL FEES AND THAT I OR MY SPONSOR IS RESPONSIBLE TO SEE THAT THEY ARE PAID IN FULL EACH MONTH.

_____ I UNDERSTAND THAT THE INTAKE FEE IS DIE IN ADVANCE IN ORDER TO BE PLACED ON THE WAITING LIST AND SECURE MY SPACE.

_____ I UNDERSTAND THAT I MUST BE INTERVIEWED BEFORE OFFICIAL ACCEPTANCE CAN BE GIVEN.

_____ I UNDERSTAND THAT THIS PROGRAM IS A MINIMUM OF 18 MONTHS. *"THERE IS NO MAGIC RELEASE DATE."*

_____ _____

APPLICANT'S SIGNATURE DATE

_____ _____

SIGNATURE OF APPROVAL DATE

STATE OF TENNESSEE
COUNTY OF BRADLEY

PROMISSORY NOTE

What is a sponsor? A sponsor is one who has agreed by signing a Promissory Note to pay the Residential Treatment Fee due Women of Hope (including but not limited to Drug Tests, Counseling Fees, unforseen medical costs, special needs (i.e., stamps, medications, phone cards, etc.).

The following are the terms and conditions of sponsoring a resident at Women of Hope:

Initial

_____ a ***non-refundable*** intake processing fee of $100.00 must be paid upon admission to the program or to hold a bed for future admission.

_____ a ***non-refundable*** fee of $50.00 Interview Fee, due at the time of service

_____ the first months Treatment Fee ($150.00 per week) is du upon admission

_____ There will be a 7-day grace period after which the resident is subject to dismissal from the program if fees have not been paid

_____ ALL FEES including fees due any outside counseling services or classes are due BEFORE release from the program.

_____ I understand this fee schedule and agree to make payments as required.

APPLICANT NAME: _____

SPONSOR NAME: (Print) _____

ADDRESS: _____

PHONE(S): _____

SPONSOR SIGNATURE: _____ DATE: _____

APPLICANT SIGNATURE: _____ DATE: _____

WITNESS: _____ NOTARY: _____