

City Rescue Mission of Lansing

Life Transformation Program for Women Application

The Life Transformation Program is a year-long faith-based substance abuse program for women who are 18 years or older. We believe that God, through His Word, can do an amazing transforming work in the lives of His children. This program does not offer psychiatric or medical treatment. The program exists to assist women in working through their addiction by learning, understanding, and applying biblical principles to their lives and learning to serve Christ with their whole hearts.

Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is - His good pleasing and perfect will. -Romans 12:2

The confidential information you share on this application will not be held against you or used to judge you. Life Transformation Program staff simply need to know the facts about you and where you are in life right now. Please remember that we will not be able to help you if you are not completely honest when you answer the questions below. Please understand that we absolutely cannot review this application if anything is left blank. If you do not understand what is being requested, please contact us and we will be happy to assist you. If a question does not apply please mark N/A.

Prior to filling out this application you **must** have read and understood the Life Transformation Program Handbook. Please do not continue until you have read the handbook.

Name: _____ Date: _____

Present Address: _____
Street Address City State Zip

Is this your permanent address? _____ (If not, please list your permanent address below)

Permanent Address: _____
Street Address City State Zip

Telephone # () _____ Cell Phone # () _____

Work # () _____ Message Phone # () _____

Please describe your current living arrangements: _____

Email address where you may be reached: _____

Are you on Facebook? _____ Under what names? _____

Are you active on any blogs / chat rooms / support group websites? (list websites and user names) _____

Have you been a guest of the City Rescue Mission of Lansing before (include Cedar Street houses)? _____ Approximate date(s)? _____

Have you applied to this program in the past? _____ If yes, approximate date? _____

Your Main Problems (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Self-Harm | <input type="checkbox"/> Alcohol addiction |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Sexual Issues |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Other: _____ | |

Summary of your current situation:

Why would you like to be in our program? _____

Why is a faith-based program the best approach for you? _____

What are you hoping to gain while in our program? _____

List your 5 biggest goals you would like to achieve while in our program

1. _____
2. _____
3. _____
4. _____
5. _____

List your 5 biggest fears about entering our program:

1. _____
2. _____
3. _____
4. _____
5. _____

Referral Source:

- Social Services Courts Parents Church Self
 Probation Counselor Other _____

Name of the person who referred you: _____

Contact Info for person who referred you: Phone: () _____

Email: _____

Information About You

Date of Birth: _____ Age: _____

City and State of Birth: _____

Social Security Number: _____

Driver's License Number and expiration date: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Race/Ethnic Group: _____

Spiritual Background

Do you feel that you have a need for God? _____ Explain: _____

What is your present relationship with God? _____

Have you committed your life to following God? _____

Date: _____ Place: _____

Are you a member of any church or religion? _____

Denominational background: _____

Where do you attend church? _____ How often? _____

Do you read the Bible? _____ How often? _____

Do you ever pray? _____ How often? _____

Have you ever witnessed or been involved with occult activities? (Satan worship, Ouija boards, levitation, rituals, séances, sacrifices, spiritism, voodoo, witchcraft, etc.) _____

If yes, explain each _____

Have you ever been abused in any of these activities? _____

Have you ever been involved in any of the following cults?

_____ Christian Science _____ New Age Movement _____ Eastern Religions

_____ Scientology _____ Jehovah's Witness _____ Kabbalah

_____ Brotherhood _____ Mormonism _____ Transcendental Meditation

Write a brief explanation of your involvement with each: _____

Do your family and friends describe themselves as Christians? _____

Denomination and name of family's church: _____

Family Relationships

Describe how you get along with your family _____

of siblings you have? _____ sisters _____ brothers _____ step / half sisters _____ step / half brothers

Are you adopted? _____ Describe your reaction to being adopted: _____

Intimate Relationships / Marital Status

___ Single ___ Married ___ Divorced ___ Separated ___ Engaged ___ Serious Relationship
If you are married, is your husband in agreement with you applying to the program? _____
Are you seeking marital counseling right now? _____ Where? _____
Are you currently seriously dating anyone? _____

Pregnancy

Are you pregnant? _____ Approximate Due Date: _____ Has a Dr confirmed it? _____

Children

Do you have any children? _____ How many? _____

List names and ages of all children you have given birth to:

- 1. _____ Age: _____ DOB: _____
- 2. _____ Age: _____ DOB: _____
- 3. _____ Age: _____ DOB: _____
- 4. _____ Age: _____ DOB: _____

Who has custody of your children? _____

What arrangements are being made for your children while you are in our program? _____

Are you on any type of government or financial assistance? _____

Will being in our program have any effect on this assistance? _____

Friendships

Do you find that you are able to make and keep friends easily? _____

How well do you resolve conflict and deal with problems in relationships? _____

How do you get along with people in general? _____

Do you struggle with any of the following?: (check all that apply)

- ___ Outbursts of anger ___ Physical violence toward others ___ Aggression
- ___ Isolation ___ Quiet simmering anger ___ Codependency
- ___ People pleasing ___ Bitterness/Unsolved Problems ___ Jealousy of others

Overall Physical and Medical Health

Are you in general good health? _____ Describe any medical concerns: _____

List any physical limitations that you may have as indicated by a physician: _____

Do you have any conditions or events in your past that would limit your ability to fully participate in the program? _____

Do you have any allergies? _____ List: _____

List any and all medication that you take:

<i>Medication</i>	<i>Dosage</i>	<i>For what reason?</i>	<i>How long have you been taking it?</i>

List all past surgeries or medical hospitalizations (include dates): _____

Do you have a communicable disease? _____ If so, please explain: _____

Do you have insurance? _____ Name of provider: _____

What was the date of your last doctor's exam? _____

Doctor's name & address _____

Eating Habits

Do you consider your eating habits to be normal or abnormal? _____

Do you have any **medically verifiable** food allergies? _____

If you have, or have ever had, a problem with food or eating, please explain in detail:

Past and Current Substance Abuse

Have you ever experimented with the following substances? (Mark those that apply by **writing in the date** that you last used that substance.)

Alcohol Hallucinogenic (Acid, LSD, etc) Morphine Inhalants
 Crank Amphetamines (Uppers) Opiates Crack
 Crystal Meth Barbiturates (Downers) Heroin Tobacco
 Marijuana Meth Amphetamines Cocaine Ecstasy
 Other (Specify: _____)

Drugs of Choice (include alcohol if applicable):

1. _____ Frequency of use: _____ Date of last use? _____
2. _____ Frequency of use: _____ Date of last use? _____
3. _____ Frequency of use: _____ Date of last use? _____
4. _____ Frequency of use: _____ Date of last use? _____

Maximum habit cost per day? _____ Longest period clean? _____

Have you ever used substitutes for drugs or alcohol when it was not available (mouthwash, inhalants, bath salts, etc.)? _____ If so, what were they? _____

Do you need to go to detoxification (detox) now? _____

How have you supported your alcohol/drug habit in the past? _____

Have you ever been involved in dealing drugs? _____

Have you ever been in an alcohol, drug, or detox program before? _____

Please list below:

<i>Date of Entry</i>	<i>Program Name</i>	<i>City / State</i>	<i>Reason for Leaving</i>	<i>Date of Discharge</i>

Were any of the above programs faith based? _____

Have you ever joined AA or a similar program? _____ If so, please describe: _____

Is there anything else about your past or current substance abuse that you would like us to know? _____

Overall Psychological Health / Past Counseling or Treatment Experience

Have you ever been diagnosed or treated for (please mark yes or no):

DID / Dissociative Disorder ADHD / ADD Schizophrenia
 Bi-Polar Disorder Borderline Personality PTSD
 Severe Trauma in past Depression Other (_____)

Have you ever experienced a life altering, traumatic event that still affects your mental health? If yes, please describe: _____

Do you experience: Flashbacks Nightmares Night Terrors Body memories

Do you have trouble sleeping? Why? _____

Have you ever experienced periods of fantasizing / daydreaming for long periods? _____

Have you ever tried to commit suicide? _____ How many times? _____

Why? _____

Have you ever been to counseling? _____ Why? _____

Have you ever received psychiatric care or been in a psychiatric hospital? _____

Why? _____

List facilities and/or counselors and/or programs where you have received help in the past:

<i>Start date</i>	<i>Facility/Counselor/ Program Name</i>	<i>City / State</i>	<i>Reason for Leaving/Ending</i>	<i>Date of Discharge</i>

Habits of Self-Harm

Do you currently participate in self-harm? If yes, what do you do? _____

Have you ever participated in any self-harm behaviors? If yes, what did you do? _____

What benefits do you gain from self-harm? _____

How frequently do you engage in self-harm behaviors? _____

Sexual Health

Are you sexually active? _____ Since what age? _____

Have you ever been a victim of:

_____ sexual abuse? _____ physical abuse? _____ ritual abuse? How old were you? _____

Have you ever been a victim of:

_____ rape? _____ incest? How old were you? _____

Have you ever been involved in prostitution? _____ For what reasons? _____

Have you ever been in an intimate relationship with another woman? _____ When? _____

To what extent? _____

How many different relationships? _____

Have you ever contracted an STD? _____ Explain: _____

Have you ever tested positive for HIV / AIDS? _____ Explain: _____

Have you ever had an abortion? _____ How many? _____

Employment History

Are you currently employed? _____ Where? _____

List last three occupations _____

Educational Background

Name of last school attended? _____

Dates of attendance? _____

Did you graduate? _____ If not, what was last grade completed? _____

Have you ever been in special education classes? _____ If yes, please list: _____

Do you have plans to further your education? _____ If yes, please describe: _____

Current Financial Status

What is your current income? _____

What are the sources of your income? _____

Do you have any financial obligations? _____ Explain: _____

What arrangements will you make for their payment while you are in the program? _____

Legal Background

Please make sure to send copies of current, relevant legal / court documents.

Have you been convicted of a felony? ____ Explain: _____

Are you wanted by the police now (warrants)? _____

Are you a criminal sexual offender? _____

Do you have any pending court dates? ____ Explain: _____

Are you currently incarcerated? ____ Total Sentence _____ Length of time remaining? _____

Name of Attorney or Legal Representative: _____

Telephone # () _____

Are you named on any restraining orders (PPOs)? ____ If yes, please describe: _____

Have you ever been on probation or parole? ____ Are you now? _____

How long? _____ Length of time remaining: _____

How often do you report? _____ In person or through mail? _____

Name of probation or parole officer? _____

Address: _____

Telephone # () _____

List present and/or future obligations that you have (i.e. lawyer, doctor/dentist appointments, urine drops, DDS/SSI and/or court appointments, etc.) _____

Is there anything else you feel the staff needs to know about you, your situation, or your application for the program? _____

Emergency Information Release

In case of an emergency, please list individuals we can release your information to:

1. _____
Name Address City State, Zip

Relationship to you Phone Number

2. _____
Name Address City State, Zip

Relationship to you Phone Number

I have read the Life Transformation Program Handbook, including the expectations, and agree to submit to the rules and staff of the Life Transformation Program (**do not sign this application until you have read the handbook and understand the program expectations**). I understand that if I have failed to answer these questions truthfully or purposely withheld information, it can be grounds for either refusal or dismissal from the program.

Applicant Signature

Date

Please Return to:

City Rescue Mission of Lansing
Life Transformation Program for Women
2216 S. Cedar Street
Lansing, MI 48910-3132

Phone: 517-485-0145 Fax: 517-485-0960

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Mission Staff Use:

Date of Application Review: _____ Date of Admission into Program: _____

Student has signed Student Commitment YES NO

Staff Member Reviewing Application:

Name

Title

Signature

Date

Referring Agency, if applicable: _____