Steps in being accepted to the program: Each prompt must be answered

1. **Please see the requirements listed on the link (www.womensrefugeofstjo.com) before completing this application.**
2. **Mail application to: P.O. Box 1430, St. Augustine, FL 32085 or scan and submit to Debbie@womensrefugeofstjo.com**
3. **Staff will review the application and contact the applicant via phone to make an appointment for the interview.**
4. **After the interview, the staff will make a decision whether the applicant is appropriate for this program at this time. Financial arrangements will be discussed at this time.**

DATE_____Release Date (If Incarcerated) _____

Name of Institution (If Incarcerated)_____

NAME_____
(Last) (First) (Middle)

ADDRESS _____
(Street) (City) (State) (Zip)

TELEPHONE NUMBER:_____ CELL NUMBER: _____

DATE OF BIRTH_____AGE_____Social Security Number_____

HT_____WT_____HAIR COLOR:_____EYE COLOR:_____RACE: _____

MARITAL STATUS: Single___Married___Separated___Divorced___Widowed ___

DRIVERS LICENSE NUMBER:_____U.S. CITIZEN? _____
*Must produce proper documentation that you are in the U.S. legally if not a citizen.

NUMBER OF CHILDREN: Boys____Girls____Will your children have a place to stay if you come to the Refuge? Yes _____No _____

AGES: _____

WERE YOU ADOPTED?_____YES _____NO

EDUCATION LEVEL: Less than high school____High School____GED ____ College ____

NAME OF CLOSEST RELATIVE _____

RELATIONSHIP:_____TELEPHONE NUMBER: _____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

WHO REFERRED YOU TO WOMEN'S REFUGE OF ST. JOHNS COUNTY?

NAME:_____ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
TELEPHONE NUMBER:_____RELATIONSHIP: _____

Do you have any medical illnesses? Yes____ No____Explain _____
_____
_____

Do you have epilepsy? Yes____ No____Explain _____
_____
_____

Do you have diabetes? Yes____No____Explain _____
_____
_____

Do you have dental needs? Yes____No____Explain _____
*****We are able to assist with fillings and extractions ONLY. We are unable to tend to additional dental needs

Are you receiving any medical care or prescribed medication at this time? Yes____No____If yes, please give doctor's name, address, and name of drugs:
_____

(Use back of form if necessary)

LIST ANY MEDICATION(S) YOU ARE CURRENTLY TAKING:

Medication	***Name/Address*** **Physician**	**Reason for Medication**

- You risk being dismissed from the program if you are not HONEST in disclosing your current medications, medical status, or your medical history.

How would you evaluate your medical condition? _____

Does/Will your health require special attention?_____If so, explain_____

***We are not a medical facility and therefore you must be detoxed before being accepted into our program.**

Would your health hinder you from full participation in all program activities and/or requirements? ***(Such as yard work, progressive physical exercise, mental alertness during classes, and a non discretionary diet)*** **_____If so, explain _____**

_____

*****Again, we are not a medical facility. Please be sure to be thorough regarding your medical needs

Do you have any mental or physical handicaps? Yes____No____If yes, please explain _____

_____

Have you ever been in a psychiatric hospital, or been under the care of a professional trained in psychology? Yes____No____If yes, who, when, and where?

_____

_____

Results of treatment by professional _____

Have you ever had moderate to severe depression? Yes____No____If yes, what were the symptoms?_____

As a result of the depression, did you see a counselor? Yes____No ____

If you have seen a counselor, give name and address:

_____

Have you ever had thoughts of suicide? Yes___No___

If yes, did you ever actually attempt to commit suicide? Yes____ No ____

Did you actually have a plan? Yes___No___

_____

_____

Are there any personal violations in your past that need restitution? ***(Money taken from a friend, irresponsible or disrespectful behavior, broken promises, etc.)***

_____

_____

IF YOU ARE ACCEPTED INTO THIS PROGRAM, IS THERE ANYONE WHO MAY FEEL THREATENED BY YOUR DECISION AND SEEK YOU OUT WITH THE INTENT TO DO HARM?

_____

If yes:

Name:_____Will you request a Restraining Order?_____

MEDICAL RELEASE

PATIENT INFORMATION

Name:_____

Date of Birth:_____Social Security # _____

MEDICAL INSTITUTION

Name: _____

Attention:_____Phone Number:_____

Address:_____

AUTHORIZATION

I hereby authorize the above institution to release my medical status to:

The Women's Refuge of St. Johns County
P. O. Box 1430
St. Augustine, FL 32085
(904) 810-4911

In regard to the following:

_____HIV

_____Tuberculosis

_____Hepatitis

_____STD

_____Psychiatric Illness

_____Other

_____ _____
Name Date

THIS FORM MUST BE COMPLETED BEFORE YOU MAY ENTER THE PROGRAM

LIFESTYLE AND BELIEFS

Do you/ have you ever smoke(d)? Yes____No____How much?_____
Date of last usage? _____

Do you/ have you ever drink alcohol? Yes___No___How frequently? _____
Date of last usage? _____

Do you use drugs? Yes___No___ Have you ever used drugs? Yes____No _____
Date of last usage? _____

What kind of drugs have you used? Marijuana____Cocaine____Amphetamines Barbiturates___PCP____Heroin___Other _____

Your age at first use of any of the above____years old.

Have you been hospitalized or treated by programs or counseling for the use of any of these drugs? Yes____No____Where?_____
When? _____

Does your husband or boyfriend use drugs as listed above? Yes____No____
What? _____

Have you ever been involved in homosexuality? Yes____No____To what extent? _____

Have you ever been involved in the following occult activities: witchcraft? satan worship?____yoga?____astrology?____Ouija boards?____ new age?____fortune telling?____other? ____

To what extent have you been involved in these activities? _____
_____

Have you been in counseling for your participation in these activities? Yes____No____

With whom did you counsel? (Name and address) _____
_____

Do you believe that the above involvements are lies of Satan and none of them are related to God's will for your life? Yes____No ____

Are you a Christian (believer in Jesus Christ)? Yes____No____
Date on which you accepted the Lord and give a brief testimony:
_____
_____
_____

FULL DISCLOSURE STATEMENT

LIST ALL YOUR CHILDREN:

(Please note if you do not know who the father of your child is; Please note if you have a child that is adopted out. Give an account for every live birth you had)

NAME	AGE	FATHER	CUSTODIAN	If not custodian, is restoration of parental rights a possibility?

LIST ANY WARRANTS, ARRESTS AND CONVICTIONS:

(Past, Present & Pending Violations)

VIOLATION(S)	Convicted YES/ NO		City, State, & Name of institution	Date of Violation	Case settled/ closed OR pending court action?

Provide brief description of each Violation/ Charge: Include any additional information we should know concerning your arrest - Weapon involved, etc.

_____

_____

_____

_____

_____

_____

LIST ALL OUTSTANDING FINANCIAL DEBTS:

(This includes old debts you're trying to forget)

DEBTOR	AMOUNT	DATE ACCUMULATED

LIST ANY DRUG OR ALCOHOL DEPENDANCY PROGRAMS YOU HAVE PARTICIPATED IN:

PROGRAM/TREATMENT FACILITY	DATES OF PARTICIPATION	VOLUNTARY OR COURT ORDER	OUTCOME OF PROGRAM

How would you evaluate your addiction now?_____

Are you legally mandated to participate in a Residential Program? __Yes___No

If yes, by whom? __Parole Board __Court __Other Explain _____
_____

If answer is court, please list county of origin: _____

Are you currently or will you be under legal supervision?____Yes ___No

Method of reporting:____Phone __Letter __In person __Other Explain
_____

How often do you report?_____How Long? _____
Time remaining? _____

Probation/Parole Officer's Name: _____
Agency:_____Phone Number:_____Address:_____
City:_____State:_____Zip:_____

Are any of the following pending against you? ***(Please check those that apply)***

__Arrest Warrant____Court Appearance __Criminal Charges __Sentencing
__Other Explain:_____
_____
_____

Have you ever been in prison?

DATE	INSTITUTION

EMPLOYMENT HISTORY

Are you employed presently? Yes____No ____

What is your present occupation and where do you work?

_____

If not employed presently, what was last date and place of employment?

_____

In the following chart, please list the required information regarding your job history of the last five years:

Type of Job	Name of Company	Period of Employment	Full or Part-time	Salary Per Week	Reason Left

Of all the jobs you have held, what type of work do you enjoy the most and why?

_____

_____

What is your total monthly income?_____

Can you be financially responsible for the monthly program fee? Yes____No____
EXPLAIN:_____

PERSONAL HISTORY FORM

PRESENTING PROBLEM:

What is your chief problem(s) to be resolved?

Are you open to God's solution to the problem?

What are your hopes for life as you seek to enter the Women's Refuge program?
(Be detailed but brief)

I certify the above is true and accurate to the best of my knowledge. I realize this information will be kept confidential.

Signature_____Date _____