House of T.I.M.E., Inc.

1200 Wynnton Road ● Columbus, Georgia 31906 ● (706) 327-6836 ● Fax (706) 327-8859

Email address: time94@houseoftime.org ● Web address: www.houseoftime.org

TIME to Recover Admission Application

APPLICANT NAME: _____ _____ _____

Last **First** **Middle**

SSN:_____ **DOB:** _____ **GENDER:** Female _____Non-Binary _____

(You must be over 18 years old) (you must identify as one of these to receive our services)

Telephone: _____ FAX: _____ Email: _____

If you do not have the means to stay in contact with us, i.e., in jail, fill out the information below as an alternative contact to represent you.

Contact Name: _____ Relationship to Applicant:_____

Telephone: _____ FAX:_____ Email: _____

Are you Homeless? Yes ____ or No____ If in question of the definition of homelessness, contact us. (You MUST be homeless to receive our services)

How long have you been homeless? _____ List all episodes of homelessness _____

_____

Homeless Certification of Applicant: **(THIS DOES NOT REPLACE YOUR HANDWRITTEN HOMELESS LETTER)**

I, _____, certify that I am homeless for the following reason (s): _____

_____

I also certify that I have exhausted all other efforts to secure housing.

_____ _____

Applicant Signature *(please type your name above for signature)* Date

In addition to completing the application, you must HANDWRITE a homeless letter describing your situation: Why are you homeless (also write about your living situation before you became homeless)? What have you done for yourself to try to get housing? Do you have any resources to assist you in getting housing? Why not? Do you have any support system (family, friends) to help you get housing? Why not? This letter must also indicate what you plan to do if you are not accepted to the House of T.I.M.E.? **If family members or friends with whom you have stayed in the past will not allow you to return to their home, they must write a letter indicating this**.

History of Substance Abuse: (you must have a substance abuse problem to receive our services)

Date of Last Use and Drug Used

_____

Drug(s) of Choice:

_____

Previous Treatment:

Name of Previous Treatment Facility _____Date Attended: _____

Legal Issues:

Are you on Probation? Yes No Parole? Yes No

Contact Information for Parole/Probation Officer: _____

Telephone: _____ FAX: _____ Email: _____

TIME to Recover Application

Do you have pending charges? _____ If so, delay court hearings for a minimum of six months if possible.

Have you been convicted of a felony? _____ If yes, what were you convicted of? _____

Date of Conviction(s) _____

Educational History:

Grade Level Completed ?_____ College/Technical? _____

Employment History:

Name of Last Employer: _____ Date of Last Employment: _____

Medical Issues: (list all medical issues you have .i.e., blood pressure, , etc.) If at all possible, a minimum of 30 days' supply of any current prescription medication(s) should be brought with you.

Condition	**Medication**	**Strength**	**Dose**	**Frequency**

TESTING REQUIRED FOR ALL APPLICANTS: All medical tests and physician's exam must be less than six months old. You **must provide evidence of medical and physical stability, in the form of a written physician's statement.** Due to the physical activities required by the program's goals and activities, ambulatory problems or other significant medical issues which could interfere with treatment will result in you being deferred from admission until those problems are resolved or will be referred to a more suitable facility.

Required:
(1) Physical examination, with history, by Physician (or PA, NP, RN)
(2) VDRL/RPR (Venereal Disease)
(3) TB Tine (Tuberculosis) or chest x-ray if client had previous positive testing
(4) Covid-19 Vaccination

If available:
(5) PSA (Psycho-Social Assessment)
(6) DSM Diagnosis (Diagnostic System Manual)
(7) HIV test

You will need to provide a urine drug screen and pregnancy test upon arrival and before final admission. If you are in active addiction, you will be referred to a detox center. If you are pregnant, you will be referred to a more appropriate facility to assist you.

Physical Limitations: _____

Psychological History: _____

Have you had any of the following thoughts:

Suicidality? ____ Homicidal? _____ Audio/Visual Hallucinations? ____Self-Mutilation? _____ Aggressiveness toward others? ____

Family History:

Are you married? If yes, list name _____ Are you in a relationship? If yes, list name _____

(We have a NO contact order while in treatment)

Do you have children? If yes, how many? _____ Last Contact with children? _____

Note: You must have dependent care in place for your children prior to admission.

Children Names	Age	Where do they currently live?

Is DFACS involved? _____ Phone_____ Counselor _____

Do you owe Child Support? If so, how much? _____

TIME to Recover Application

Financial Assessment: (Note: Please fill in amount(s) or -0- on each line **– do not leave blank.)**

Source of Income	Amount
Supplemental Nutritional Assistance Program	
MEDICAID Health Insurance	
MEDICARE Health Insurance	
State Children's Health Insurance	
WIC	
VA Medical Services	
TANF Child Care Services	
TANF Transportation Services	
Other TANF-Funded Services	
Temporary Rental Assistance	
Section 8, Public Housing, Rental Assistance	
Earned Income	
Unemployment Insurance	
SSI	
SSDI	
Veteran's Disability	
Private Disability Insurance	
Worker's Compensation	
General Assistance	
Retirement (Social Security)	
Veteran's Pension	
Pension from Former Job	
Child Support	
Alimony (Spousal Support)	
Other: _____	

REMINDER

Required Documents:

- **Completed application**
- **Letters of homelessness (client, referring agency, friends/relatives)**
- **Physical examination**
- **Letter of medical stability**
- **Lab Test Results**

If you have any of these documents, please bring them with you

- **Social Security Card**
- **Birth Certificate**
- **Driver's License or Picture I.D.**
- **Marriage Certificate (If married)**
- **Divorce Papers (If divorced)**

NOTE: If you are unable to supply us with a Physical Examination, Letter of Medical Stability and/or Lab Results, you can write a letter stating you need these services or call to discuss how we can help you. PLEASE NOTE…Your acceptance into the program is BASED UPON THE RESULTS OF THESE REPORTS. A telephone interview is required before your arrival.

I certify that the above information is true and correct to the best of my knowledge. I certify that I have no assets, such as a home, etc., and further understand that if I am accepted into the program and this information is verified and not true, I will no longer qualify to remain in the program. I certify I have read the TIME to Recover Admission Information.

_____ _____

Applicant Signature *(please type your name above for signature)* Date

TIME to Recover Application

REFERRING AGENCY: _____

Mailing Address: _____

_____

Contact Name: _____ Title of Referring Contact: _____

Telephone: _____ FAX: _____ Email: _____

Date of admission to your facility: _____

Presenting Problem: _____

Current mental status: _____

Diagnosis from DSM-IV: (If Available/Applicable):

Axis I: _____ Axis II: _____

Comments/Additional Information:

_____

_____

Referring Agency Certification of Homelessness

This participant is found to be homeless for the following reason (***circle one or more reasons and attach documentation***):

A. **Participant is sleeping in place(s) not meant for human habitation, or person is leaving short-stay facility (30 days or less), and without assistance would have to sleep in a shelter or in a place not meant for human habitation.** Documentation, on letterhead, may include letters or memos from police and/or sheriff, DFACS, homeless outreach agencies, Traveler's Aid, churches, the address used for public assistance checks, etc. Absent any of this information, obtain signed statement by the homeless person detailing the reasons for her homelessness.

B. **Participant is homeless and living in a shelter, as defined by H.U.D.** Documentation, on letterhead, must include verification via letter or memo, on letterhead, by the sheltering agency.

C. **Participant is homeless and living in transitional housing or has been in an institution for less than 30 days (crisis center) and is being referred by homeless service agency (homeless service agency may include mental health provider(s).** Documentation, on letterhead, must include evidence via letter or memo from the homeless service agency accompanied by the original 3rd party documentation, as per Part II, Items A or B, above.

D. **Participant is within one week of eviction.** Documentation, on letterhead, must include evidence via letter or memo that that participant is being evicted within seven (7) days from dwelling unit; no subsequent residence has been identified; AND participant lacks the resources and support networks needed to access housing (documentation should include an appropriate eviction notice).

E. **Participant is being discharged within the week from an institution and has been a resident there for more than 30 consecutive days, no subsequent residences have been identified, and without assistance participant would have to sleep in a shelter or in a place not meant for human habitation.** Documentation, on letterhead, must include evidence from the institution or a homeless service provider (may be a community mental health agency) that the institution has discharged OR will discharge the participant within 7 days; that no subsequent residence has been identified; AND that the participant lacks the resources and support network needed to obtain housing without assistance.

Certification by Referring Agency:

Based on representation made to me by the participant, I find her to be homeless and eligible for assistance.

_____ _____

Agency Signature *(please type your name above for signature)* Date