



Christian Recovery Centers

Program Director: Ronald Byers, CCIT

Financial Director: Doug Brooks, CARES, CPS-AD, Recovery Coach

Judicial Affairs Coordinator: Jason Oglesby

PO. Box 1913 216 Wrightsville Ave
Dublin, GA 31040 East Dublin, GA 31027

Phone: (478) 205-5487 Fax: (478) 304-1214

DougCRCG@gmail.com / Ronaldlloydbyers@msn.com / Jasonoglesby61@gmail.com

NAME: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: (____) _____ BIRTHDAY: _____

RACE: _____ SOCIAL SECURITY NUMBER: _____

EMERGENCY CONTACTS:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: (____) _____

OTHER INFORMATION:

MARITAL STATUS: M _____ SEP _____ W _____ D _____ S _____

IF DIVORCED OR SEPARATED, GIVE DATE(S) _____

IF MARRIED, GIVE SPOUSE'S NAME: _____

HOW LONG MARRIED: _____

NAME AND AGE OF DEPENDENTS: _____

PROBATION: YES OR NO PROBATION OFFICERS NAME: _____ MANDATED: YES OR NO

PROBATION OFFICERS #: _____ COUNTY: _____

ANY CHURCH AFFILIATION: _____

PASTOR'S NAME: _____

CHURCH OR PASTOR'S PHONE NUMBER: (____) _____

EDUCATION LEVEL: HIGH SCHOOL: _____ COLLEGE: _____ OTHER: _____

Health Information:

Please list any physical conditions. Make note of any that would hinder you from participating in our daily work schedule. (please recognize that we are not a medical facility and any pre-existing conditions need to be addressed before entering.)

List any medications that you must take on a regular basis and the dosages prescribed.

Are you allergic to any medications? Yes: _____ No: _____ If yes, list those medications.

CHRISTIAN RECOVERY CENTERS IS NOT A MEDICAL FACILITY AND IS UNABLE TO ADMINISTER OR PROVIDE MEDICAL CARE FOR STUDENTS. MAKE SURE THAT YOU HAVE ANY NON-NARCOTIC MEDICATION THAT IS NECESSARY FOR YOUR MEDICAL HEALTH, ALTHOUGH WE RECOMMEND THAT ALL MEDICAL NEEDS ARE ADDRESSED BEFORE ENTERING, WE UNDERSTAND THAT EMERGENCIES OCCUR. PLEASE LIST THE PERSON THAT WILL BE RESPONSIBLE FOR ANY MEDICAL FEES THAT ARE INCURRED WHILE YOU ARE HERE. THESE WILL INCLUDE DOCTOR, HOSPITAL, TRANSPORTATION FEES, ETC.

MEDICAL INSURANCE COMPANY: _____

NAME OF CARDHOLDER: _____

POLICY NUMBER: _____

IF YOU DO NOT HAVE INSURANCE, PROVIDE THE NAME, ADDRESS, AND PHONE NUMBER OF THE PERSON RESPONSIBLE FOR YOUR MEDICAL EXPENSES.

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

Drug and/or alcohol use information:

STUDENT IDENTIFICATION

NAME: _____

DATE OF BIRTH: ____/____/____

ADDRESS: _____

1. HEIGHT: _____

2. WEIGHT: _____

3. RACE: _____

4. DESCRIBE ANY TATTOOS OR IDENTIFYING MARKINGS:

5. DO YOU HAVE A VALID DRIVER'S LICENSE: YES _____ NO _____ IF YES, PLEASE PROVIDE COPY.

6. SOCIAL SECURITY #: _____ - _____ - _____

7. COLOR OF EYES: _____

8. COLOR OF HAIR: _____

9. DO YOU WEAR GLASSES? YES _____ NO _____

10. DO YOU HAVE ANY VISIBLE BODY PIERCINGS? YES _____ NO _____ IF YES, PLEASE DESCRIBE.

AGREEMENT: NEEDS TO BE SIGNED AND PLACE IN YOUR FILE AFTER YOU HAVE READ THE RULES AND POLICIES OF CHRISTIAN RECOVERY CENTERS.

I, _____, have read or had the rules and regulations read to me. I agree to follow all the rules and regulations while enrolled as a student at Christian Recovery Centers. I also understand that I am subject to random drug/alcohol screens as well as room and personal searches. I understand that any positive drug/alcohol screen or gross violation of the rules may result in my immediate dismissal or suspension without refund of fees paid.

I, _____, understand that any and all entry fees and maintenance fees must be paid in full in order to successfully complete Christian Recovery Centers. If fees are not paid in full, I will not receive a completion certificate. This applies to mandated students as well as volunteer students.

I, _____, understand that Christian Recovery Centers is not responsible for any accidents that occur on CRC property. I assume and accept the responsibility for any medical expenses, including doctor visits, medication, and trip fees incurred while here. I also understand that unless it is an emergency, I must have the money on my account to cover all medical fees and trip fees prior to being transported.

I, _____, understand that fees are \$1250.00 for intake, this includes \$250.00 intake fee and \$1000.00 for one month's rent. Then \$1000.00 a month every month following the first month. Under certain circumstances, the intake fee will be \$1500.00 and \$1250.00 a month every month following the first month. If this affects you, you will be notified beforehand. Everyone starts out at a minimum of 9 months, unless otherwise stated by court/probation order.

Residents Signature: _____ Date: _____

Release of Information

I, _____ do allow Christian Recovery Centers of GA to release information to the people listed below, in the form of speech, email, text, or any other form accessible to CRC.

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____
4. _____ Relationship _____
5. _____ Relationship _____
6. _____ Relationship _____
7. _____ Relationship _____
8. _____ Relationship _____
9. _____ Relationship _____
10. _____ Relationship _____

Signature: _____ Date: _____

Witness: _____ Date: _____



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Rules and Regulations

1. NO SMOKING OUTSIDE THE SMOKING AREA (BACK YARD IS SMOKING AREA), USE ASH TRAYS PROVIDED (DO NOT THROW YOUR CIGARETTES ON THE GROUND) VAPS ARE NOT ALLOWED.
2. DO NOT LINGER OR CONGREGATE IN THE FRONT YARD OR FRONT PORCH.
3. DO NOT USE YOUR CELL PHONE IN THE FRONT YARD OR FRONT PORCH.
4. ALL MUSIC MUST BE CHRISTIAN IN NATURE AND CANNOT BE PLAYED LOUD ENOUGH TO BE HEARD OUTSIDE.
5. WHEN LEAVING A ROOM, TURN OFF LIGHTS AND AC/HEATING UNITS.
6. NO SLEEPING, USING CELL PHONES, OR CAUSING DISRUPTIVE BEHAVIOR DURING ANY GROUPS, DEVOTION, OR CHURCH.
7. NO ARUGING OR FIGHTING. KEEP YOUR HANDS TO YOURSELF.
8. NO CUSSING OR USE OF ANY PROFANITY AT ANY TIME.
9. YOU MUST BE ON TIME FOR ANY SCHEDULED EVENTS.
10. YOU MUST PARTICIPATE IN BIBLE STUDIES, SERVICES, DEVOTIONS, ETC.
11. CLEAN UP AFTER YOURSELF, THIS INCLUDES BUT NOT LIMITED TO DISHES, PERSONAL BELONGINGS, MAKE YOUR BED, PICK UP YOUR CLOTHS, DO NOT LEAVE ITEMS LAYING ON FLOOR, ETC.
12. YOU MUST TAKE A BATH EVERYDAY USING WATER AND SOAP, WASHING FULL BODY AND HAIR. PUT ON CLEAN CLOTHS, USE DEODORANT, BRUSH TEETH, COMB HAIR.
13. THE TELEVISION IS TO BE TURNED OFF WEEKDAYS FROM 8am-4pm, SATURDAYS FROM 8am-12pm, BEFORE LUNCH ON SUNDAYS.
14. CELL PHONES ARE A PRIVILAGE AND STAFF HAS THE RIGHT TO INSPECT ANY RESIDENTS CELL PHONE AT ANYTIME FOR INAPPROPRIATE CONTENT.
15. RESIDENTS ARE NOT ALLOWED A CELL PHONE FOR A MINIMUM OF 2 WEEKS, AFTER THE FIRST 2 WEEKS RESIDENTS WILL BE REEVALUATED FOR CONSIDERATION OF HAVING USE OF A CELL PHONE. NO NEW RESIDENTS WILL BE ALLOWED A CELL PHONE WHILE LIVING AT THE INTAKE HOUSE (CHURCH).
16. DO NOT ALLOW A RESIDENT WITHOUT PHONE PRIVILIGES TO USE YOUR CELL PHONE.
17. NO CELL PHONE USE DURING SCHEDULED ACTIVITIES SUCH AS GROUPS, DEVOTION, BIBLE STUDY, CHURCH, WHILE DOING CHORES, ETC. CELL PHONES MUST BE TURNED IN EVERY NIGHT BY 10PM.
18. FOR THOSE THAT DO HAVE THE PRIVILEGE OF A CELL PHONE, **NO SOCIAL MEDIA ACCOUNTS ALLOWED.** (FACEBOOK, TWITTER, SNAPCHAT, INSTAGRAM, ETC.)

19. INTAKE FEES ARE \$1250.00 FOR INTAKE, THIS INCLUDES \$250.00 INTAKE FEE AND \$1000.00 FOR ONE MONTH'S RENT. THEN \$1000.00 A MONTH EVERY MONTH FOLLOWING THE FIRST MONTH. UNDER CERTAIN CIRCUMSTANCES, THE INTAKE FEE WILL BE \$1500.00, AND \$1250.00 A MONTH FOLLOWING THE FIRST MONTH. IF THIS AFFECTS YOU, YOU WILL BE NOTIFIED BEFOREHAND. IF A RESIDENT DOES NOT HAVE AN EBT CARD, THE RESIDENT WILL BE CHARGED \$250 A MONTH FOR FOOD, THAT EQUALS \$62.50 A WEEK.
20. CRC WILL APPLY FOR EBT ON YOUR BEHALF, THESE CARDS WILL BE HELD BY STAFF IN ORDER TO PURCHASE FOOD FOR ALL RESIDENTS. IF A RESIDENT DECIDES TO LEAVE THE PROGRAM FOR ANY REASON, BEFORE THE CARD IS RETURNED TO THAT RESIDENT, ANY MONEY THAT WAS ADDED TO THE CARD FOR THAT MONTH WILL BE USED TO COVER ANY FOOD CONSUMED BY THAT RESIDENT FOR THE NUMBER OF DAY IN PROGRAM.
21. YOU MUST HAVE PERMISSION TO LEAVE PROPERTY. IF YOU DO LEAVE PROPERTY WITHOUT PERMISSION, YOU WILL BE FINED \$50 FOR FIRST OCCURRENCE, \$100 FOR SECOND OCCURRENCE, AND FINE OF \$150 OR DISMISSED FOR THIRD OCCURRENCE.
22. YOU ARE NOT ALLOWED TO TAKE ANY OTHER RESIDENT OFF PROPERTY WITHOUT PERMISSION.
23. YOU MUST SIGN OUT AND BACK IN EVERYTIME YOU LEAVE PROPERTY.
24. NO DRUGS OR ALCOHOL ARE PERMITTED ON OR OFF PROPERTY.
25. IF CRC PROVIDES TRANSPORTATION FOR ANY RESIDENT, THERE WILL BE MINIMUM CHARGE OF \$10.00 BUT CAN BE HIGHER.
26. SHOW RESPECT TO STAFF AND OTHER RESIDENTS AT ALL TIME.
27. IF YOU ARE ASKED TO DO SOMETHING BY STAFF, BE RESPECTFUL AND DO WHAT HAS BEEN ASKED OF YOU.
28. ALL TV'S MUST BE TURNED OFF BY 10pm.
29. LIGHTS OFF BY 11pm.
30. CURFEW IS 9pm ON WEEKDAYS AND 10pm ON WEEKENDS. (EXCEPTION FOR WORK)
31. IF YOU CALL IN SICK FROM WORK AND MISS CLASSES, YOU MUST STAY IN YOU ROOM FOR THAT DAY. YOU WILL BE ALLOWED TO TAKE 3 SMOKE BREAKS, BUT YOU MUST RETURN TO YOUR ROOM WHEN YOU FINISH YOUR CIGARRETT.
32. NO CELL PHONE ALLOWED IN CLASS OR THE SANCTUARY. IF YOU ARE CAUGHT WITH A CELL PHONE IN EITHER, YOUR PHONE WILL BE CONFISCATED.
33. ANY RESIDENT THAT DOES NOT BRING THEIR CHECK TO STAFF WILL BE FINED \$50.00.
34. THEFT OF ANY KIND WILL NOT BE TOLERATED.

NAME(PRINTED): _____ **DATE:** _____

SIGNATURE: _____

NOTE: RULES AND REGULATIONS ARE SUBJECT TO CHANGE AT THE DISCRETION OF STAFF.

Christian Recovery Centers

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GENERAL CONSENT FOR CARE AND RECOVERY

Part I: Consent for Care and Recovery

I, _____, hereby authorize CRC staff and its representatives to render alcohol/drug abuse recovery to me. I understand that routine health care is confidential and voluntary and may involve provider office visits which include history taking, examinations, administration of medications, laboratory tests, and/or minor procedures. I understand that I may discontinue services at any time.

Signature of Client

Date

Witness

Date

Part II: Withdrawal of Consent for Care and Recovery

I, _____ WITHDRAW THIS CONSENT, effective _____.

Client/Representative Signature

Date

Witness

Date

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Christian Recovery Centers of Georgia

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Client Rights

Clients at CRC are guaranteed the following rights while they are in recovery:

1. Right to a humane recovery or habilitation environment that affords reasonable protection from harm, exploitation, and coercion.
2. Right to be free from physical and verbal abuse.
3. Right to be free from the use of physical restraints and seclusion unless it is determined that there are no less restrictive methods of controlling behavior to reasonably ensure the safety of the client and other persons:
4. Right to be informed about plan of recovery and to participate in the planning, as able.
5. Right to be promptly and fully informed of any changes in the plan of recovery.
6. Right to accept or refuse recovery, unless it is determined through established authorized legal processes that the client is un-able to care for himself or is dangerous to himself.
7. Right to be fully informed of the charges for recovery.
8. Right to confidentiality of client records.
9. Right to have and retain personal property which does not jeopardize the safety of the client or other clients or staff and have such property treated with respect.
10. Right to converse privately, have convenient and reasonable access to the telephone and mails, and to see visitors, unless denial is necessary for recovery and the reasons are documented in the client's recovery plan.
11. Right to be informed of the program's complaint policy and procedures and the right to submit complaints without fear of discrimination or retaliation and to have them investigated by the program within a reasonable period of time.
12. Right to have access to their own client records and to obtain necessary copies when needed.
13. Right to obtain a copy of the program's most recent completed report of licensing inspection from the program upon written request. The program is not required to release a report until the program has had the opportunity to file a written plan of correction for the violations as provided for in these rules.
14. Right to attend an outside meeting weekly.

I, _____, have read and understood the previous rights that are guaranteed to me while I am at the CRC.

Client Signature

Date

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AUTHORIZATION TO RELEASE INFORMATION TO COURT AUTHORITIES

Client's Name: _____ DOB: _____

Probation Officer: _____ SSN #: _____

I hereby authorize CRC to release all information regarding my recovery to any probation office or court authority that has jurisdiction over me. I further authorize any court authority or probation office to release any information about me to CRC.

Client Signature: _____ Date Signed: _____

THIS AUTHORIZATION IS VALID FOR THE DURATION OF RECOVERY AT CRC.



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Yes or No 1. Do you have a valid driver's license?

Yes or No 2. Do you have social security card?

Yes or No 3. Do you have GA ID of any kind?

Yes or No 4. Do you have a birth certificate?

_____ 5. When was the last time you had a valid ID?

Yes or No 6. Do you have ID on you or at home?

Yes or No 7. Do you understand that is a requirement to be in this program to have or acquire a valid ID?

Yes or No 8. Have you ever had an ID?

Probation Information

Student Name: _____

Entry Date: _____ DOB: _____ SS#: _____

Felony Probation

Sentencing County Name: _____

Probation Officer Name: _____

Probation Officer Number: _____

Probation Officer Email: _____

Supervising Probation Officer: _____

Supervising PO Email: _____

Supervising PO Phone: _____

Misdemeanor Probation

Sentencing County Name: _____

Probation Officer Name: _____

Probation Officer Number: _____

Probation Officer Email: _____

Mandated Program Participants

Sentencing County Name: _____

Supervising County Email: _____

Length of Mandation: _____

If Man is Willing,



God is Able

Mailing Address:

PO. Box 1913, Dublin GA, 31021

Physical Address:

216 Wrightsville Ave, East Dublin, GA 31027

Phone:

478-205-5487

Fax:

478-304-1214

Physical Address:

216 Wrightsville Ave, East Dublin, GA 31027

Program Director:

Ronald Byers, CCIT

Financial Director:

Doug Brooks, CARES, CPS-AD

Judicial Relations Director:

Jason Oglesby

Date: _____

Resident name: _____

Resident DOB: _____

Resident last 4 SSN: _____

This is to notify you that the above-named person is a resident at Christian Recovery Centers. His signature below indicates that he provides his informed consent to speak to the staff of Christian Recovery Centers—including but not limited to our staff Registered Nurse, Cori Huff—regarding his treatment at your facility. This includes speaking on the phone regarding any tests, bloodwork, or course of treatment, as well as releasing records to Christian Recovery Centers. If your office requires a separate release of information, we request that it be sent to the email above. The above-named resident has been informed that this consent may be revoked at any time, and that it expires 12 months from the signed date.

Professionally Submitted,

Cori Huff, RN

I hereby provide my consent for a release of information for any and all medical records to Christian Recovery Centers.

Residents signature: _____

Date: _____

