

# NEW LIFE PROGRAM ADMISSIONS APPLICATION

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This ***New Life Program*** application is for the sole purpose of Harmony House Mission, Inc. understanding your problems (causes, frequency, and effects) so that we may assist you in becoming a CHANGED and spiritually healthy person. The following questions are very personal, so please answer carefully and honestly. The information you provide will be held in the strictest confidence and will not be shared with anyone without your permission, other than the appropriate staff of Harmony House Mission, Inc. or the judicial system.

## **I AM WILLING?** Answer YES, NO, NOT SURE to the following questions?

I am willing to participate in Christ-centered classes, meetings, and groups.	Y	N	Not Sure
I am willing to make healthy choices in my life.	Y	N	Not Sure
I am willing to do the work to improve my situation	Y	N	Not Sure
I am willing to volunteer in the community	Y	N	Not Sure
I am willing to follow the directions given to me.	Y	N	Not Sure
I am willing to share a room with someone else.	Y	N	Not Sure
I am willing to get along with other people.	Y	N	Not Sure
I am willing to participate in the general upkeep of the facility.	Y	N	Not Sure
I am willing to accept the consequences of my choices, positive or negative.	Y	N	Not Sure
I am willing to treat others and their personal property with respect.	Y	N	Not Sure
I am willing to follow the rules and guidelines of the Mission.	Y	N	Not Sure
I am willing to submit toxicology screening.	Y	N	Not Sure
I am willing to submit to Covid testing	Y	N	Not Sure
I am willing to have my family and / or concerned other(s) Participate in my recovery?	Y	N	Not Sure
I am willing to stay clean & sober?	Y	N	Not Sure

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## PERSONAL INFORMATION:

NAME:

Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone Number: \_\_\_\_\_ Place of Birth (City, State) \_\_\_\_\_

Driver's License #: \_\_\_\_\_ or State ID# \_\_\_\_\_

Automobile Or Other Transportation mode: YES NO Year, Make & Model: \_\_\_\_\_

Auto Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred to Harmony House Mission, Inc. by: \_\_\_\_\_

## FAMILY INFORMATION:

Marital Status: SINGLE MARRIED DIVORCED SEPARATED

Name of Spouse: Last \_\_\_\_\_ First \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Number of Children: \_\_\_\_\_

Are your Parents Living? Father Yes No Mother: Yes No

Father's Name: \_\_\_\_\_ AGE \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mother's Name: \_\_\_\_\_ AGE \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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## EMERGENCY CONTACT INFO:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## MILITARY SERVICE INFO:

Are you a veteran? YES NO Branch: \_\_\_\_\_ War: \_\_\_\_\_

Discharge date: \_\_\_\_\_

Are you eligible to receive military benefits? YES NO

List Training and courses you completed while serving in the  
military: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## EDUCATION / EMPLOYMENT INFO:

High School: 9 10 11 12 College: 1 2 3 4 Graduate School: 1 2 3 4

Did you graduate High School? YES NO Did you earn your GED? YES NO

What were your favorite subjects in school: \_\_\_\_\_

Most Recent Employer: \_\_\_\_\_ Date: \_\_\_\_\_

To: \_\_\_\_/\_\_\_\_/\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_

Position/Occupation: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

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## FINANCIAL INFO:

Any Income    YES   NO    Total Each Month \$  
Food Stamps    YES   NO    Amount Awarded \$  
Disability      YES   NO    Monthly Amount \$  
Other            YES   NO    Monthly Amount \$

## PERSONAL INFORMATION:

Date of last alcohol use: \_\_\_\_/\_\_\_\_/\_\_\_\_    Date of last drug use: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever attended any substance abuse programs?    YES    NO

VA \_\_\_\_ Cornerstone \_\_\_\_ Mission \_\_\_\_ AA \_\_\_\_ NA \_\_\_\_ Other \_\_\_\_\_

Dates: Attended: \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

What issues are you currently dealing with in your life?

\_\_\_\_ Addictions    \_\_\_\_ Abuse    \_\_\_\_ Hurt    \_\_\_\_ Hopelessness  
\_\_\_\_ Homelessness    \_\_\_\_ Other \_\_\_\_\_

## MEDICAL INFORMATION:

Which type of medical insurance do you have?    \_\_\_\_ Medicaid    \_\_\_\_ Medicare    \_\_\_\_ VA  
\_\_\_\_ Employer Insurance Plan    \_\_\_\_ HIP    \_\_\_\_ Private Insurance    \_\_\_\_ No Insurance  
\_\_\_\_ RID Number

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Medications Currently Taking:

Will you need medication refills? Explain:

Medication

Strength

Dosage

Reason for Med

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Are you currently under a Physicians' care? YES NO Date last seen: \_\_\_\_/\_\_\_\_/\_\_\_\_

What is the reason(s) you are under a Physician's care?

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Physicians' Name: \_\_\_\_\_

Physician's Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician's Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Do you have any Allergies? \_\_\_\_\_

Have you ever been diagnosed with any mental or emotional ailments? YES NO

If YES what are they and when?

Diagnosis: \_\_\_\_\_ Date last seen: \_\_\_\_/\_\_\_\_/\_\_\_\_

Diagnosis: \_\_\_\_\_ Date last seen: \_\_\_\_/\_\_\_\_/\_\_\_\_

Diagnosis: \_\_\_\_\_ Date last seen: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever planned or attempted suicide? YES NO *If yes, circle one: Planned  
Attempted Both*

Are you currently under the care of a Psychiatrist or Mental Health Counselor? YES NO

Name of Psychiatrist or Counselor: \_\_\_\_\_

Date last seen: \_\_\_\_/\_\_\_\_/\_\_\_\_

Care Provider Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Next Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

When was the last time you were a patient overnight in a hospital? \_\_\_\_\_

Why were you hospitalized? \_\_\_\_\_

Have you ever been tested for HIV? YES NO Results: Negative \_\_\_\_ Positive \_\_\_\_

Have you ever been tested for TB? YES NO Results: Negative \_\_\_\_ Positive \_\_\_\_

Have you ever been tested for Hep. A,B,C? YES NO Results: Negative \_\_\_\_ Positive \_\_\_\_

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**ADDICTION HISTORY:** Check all addictions abused in the past 5 years:

Alcohol	GHB/ GBL	Pornography / Sex	Do You Use Tobacco Products
Amphetamine/ Stimulants <i>e.g. Adderall, Ritalin</i>	Hallucinoens <i>e.g. Acid/LSD, PCP, Shrooms</i>	Prescription Opioids <i>e.g. Larcet, Lortab, Methadone,</i>	YES NO
		<i>Morphine, Oxycontin, Suboxone</i>	
Barbiturates	Heroin	Spice	
Bath Slats	Inhalants /Huffing	Steroids	
Benzodiazepines/Sedatives <i>e.g. Librium, Klonopin, Valium, Xanax</i>	Kratom	Tobacco/Nicotine	
Cocaine	Marijuana, THC	Gambling	Over the Counter
	Methamphetamine	Ecstasy	Other Not Listed:
<b>WHICH IS YOUR PRIMARY ADDICTION?</b> _____ <b>WHICH IS YOUR SECONDARY ADDICTION?</b> _____			

**LEGAL INFORMATION:**

Have you ever been arrested or convicted of a crime? YES NO

Are you a registered sex offender? YES NO

What was the crime(s) and how much time did you serve?

\_\_\_\_\_

\_\_\_\_\_

Do you have any outstanding or pending cases against you? YES NO

What are the charge(s) against you? \_\_\_\_\_

When is your next court date? \_\_\_\_/\_\_\_\_/\_\_\_\_

Attorney's Name: \_\_\_\_\_

Attorney's Phone#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Jurisdiction/Court Handling case: \_\_\_\_\_

Are you currently, or have you ever been required to register as a Sex Offender? YES NO

Are you: On Parole? \_\_\_\_\_ On Probation? \_\_\_\_\_ Length of time \_\_\_\_\_

Name of Parole or Probation Officer: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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## RELIGIOUS BACKGROUND

Have you ever attended church? YES NO

Do you believe in God? YES NO Do you pray? YES NO

Is the Bible important to you? YES NO Why?

With my signature, I attest that the answers that I have given are true and complete. I also understand that if I have deceived Harmony House Mission, Inc. by giving inaccurate or incomplete answers, I may be removed from the Life Change Program.

Signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Guest Name: \_\_\_\_\_

New Life Campus Director: \_\_\_\_\_

New Life Campus Director Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_