

*Whole Family Community Initiative (WFCI)*  
*House of Ruth*

**322 Summit Avenue, Connersville, IN 47331 – Phone 765-825-3333**  
**scranfill@houseofruthin.org**

*“Women Helping Women”*

**POTENTIAL RESIDENT APPLICATION**

Please answer all questions accurately and correctly. Please **do not** leave any blanks on this application, as this will delay processing. Please write **N/A** or strike through sections that **do not** apply. A personal photo **must** accompany all applications. House of Ruth (HOR) reserves the right to deny applicant admission to the program.

**INFORMATION ABOUT YOU**

Date \_\_\_\_\_ Name \_\_\_\_\_ Name you go by \_\_\_\_\_

Present Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_ (optional)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_ Race \_\_\_\_\_

Current Relationship Status:

Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Living with someone \_\_\_\_\_

Do you have children? Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_

Highest grade completed \_\_\_\_\_ Need to work on your GED? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever applied to be, or been, a resident of HOR? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when? \_\_\_\_\_

Why do you to come to HOR? \_\_\_\_\_

\_\_\_\_\_

What would you like to have happen in your life during your stay at HOR? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did you hear about HOR? \_\_\_\_\_

\_\_\_\_\_

Please state reasons you cannot live with a family member \_\_\_\_\_

\_\_\_\_\_

**OFFICE USE ONLY**

Date Received: \_\_\_\_\_

Accepted: Yes \_\_\_\_\_ No \_\_\_\_\_

Comments:

**MEDICAL CONSIDERATIONS**

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Approximate due date \_\_\_\_\_

A doctor **has** confirmed my pregnancy Yes \_\_\_\_\_ No \_\_\_\_\_

I have experienced or been treated for: (check all that apply)

- Psychological issues-depression, anxiety, bipolar, personality disorder, thought disorder, hallucinations
- Suicidal thoughts or attempts
- Recurring injuries requiring medical treatment
- Hospitalization (major surgery, overdose, etc.)
- Eating Disorders

Please provide explanations for all boxes checked above \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Current Prescription Medications***

<i>Medication Name</i>	<i>Dosage</i>	<i>Reason for Medication</i>	<i>Length of Time Taken</i>

***History of Chemical Dependency***

List all drugs of choice used within the last twelve (12) months \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

At what age did you begin using alcohol/drugs? \_\_\_\_\_

How long have you known your alcohol/drug use to be problematic? \_\_\_\_\_

How often do you drink alcohol/use drugs? \_\_\_\_\_

Do most of your social activities involve drug/alcohol use? Yes \_\_\_\_\_ No \_\_\_\_\_

Have drugs/alcohol affected your ability to hold a job? Yes \_\_\_\_\_ No \_\_\_\_\_

How much do you consume at one time? Alcohol \_\_\_\_\_ Drugs \_\_\_\_\_

When did you last use? Alcohol \_\_\_\_\_ Drugs \_\_\_\_\_

Are you presently in treatment? Yes \_\_\_\_\_ No \_\_\_\_\_ if yes, where? \_\_\_\_\_

\_\_\_\_\_

Please list any past treatment/detoxification programs in which you were a participant:

<i>Facility Name</i>	<i>Length of Stay</i>	<i>Completed</i>	<i>Year</i>

**LEGAL HISTORY**

Applicants **must** obtain and submit a copy of their Criminal History Report to HOR from the local city police/sheriff's department.

Have you ever been arrested/incarcerated? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many times? \_\_\_\_\_ Have you been incarcerated for any of the following? (Check all that apply)

- Arson
- Assault
- Domestic Violence
- Sexual Assault
- Violent Crime

Please provide a brief explanation for boxes checked above \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list, and briefly explain, any pending court dates \_\_\_\_\_  
 \_\_\_\_\_

Name of legal representative \_\_\_\_\_

Judge's name \_\_\_\_\_ Court \_\_\_\_\_ County \_\_\_\_\_

Are you currently on probation or parole? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how long \_\_\_\_\_

How much time remaining? \_\_\_\_\_ How often do you report? \_\_\_\_\_

Report by: mail \_\_\_\_\_ in person \_\_\_\_\_

Name of probation/parole officer \_\_\_\_\_

Address \_\_\_\_\_

County \_\_\_\_\_ Phone \_\_\_\_\_

**SOURCES OF INCOME** (Check all that apply)

Employment Amount \_\_\_\_\_ Employer \_\_\_\_\_

Welfare Amount \_\_\_\_\_

SSI Amount \_\_\_\_\_

Disability Amount \_\_\_\_\_

Child Support Amount \_\_\_\_\_

Sponsorships Amount \_\_\_\_\_ (income from other sources-friends, family, churches, etc. that can be used to offset program fees)

**ACKNOWLEDGEMENTS AND SIGNATURES**

In completing this application and initialing the statements below, I hereby acknowledge:

HOR is a faith-based facility and, as a result, I will be required to attend church services three times per week, attend prayer meetings, and attend Bible studies and chapel services. **INITIALS [            ]**

I must commit to working a highly-disciplined spiritually-based program for the next 9-12 months, once admitted to HOR. **INITIALS [            ]**

HOR does not permit the use of alcohol, drugs, or tobacco while in the program. Violation will subject me to discharge from the program. **INITIALS [            ]**

HOR has a strict dress code; enforcing modesty and good personal hygiene. I agree to be appropriately dressed and well-groomed daily. **INITIALS [            ]**

I willingly submit to the rules, regulations, and policies of HOR and allowing Christ to change my life. **INITIALS [            ]**

HOR will conduct periodic drug tests/screens, and that a positive result may result in immediate discharge from the program, as well as notification to my probation/parole officer as mandated by law, if one is assigned. **INITIALS [            ]**

HOR is **not responsible** for my medical needs/attention, due to transportation to non-program related venues. **INITIALS [            ]**

HOR has my authorization to conduct a criminal background check. **INITIALS [            ]**

HOR staff may talk with individuals who have provided treatment to me in the past. This may include, but is not limited to, doctors, hospitals, clinics, or other mental/health care facilities. **INITIALS [            ]**

I, \_\_\_\_\_, acknowledge that, to the best of my knowledge, I have provided true and accurate information in completing this application. Furthermore, I authorize HOR to verify validity when deemed necessary. I give HOR staff permission to communicate with my support network to determine eligibility for admission. I also allow HOR to speak with my representative, legal or otherwise, to assist with admission, recovery, or aftercare. I understand that any false or misleading information could result in denial for admission, or discharge from the program.

By signing below, I acknowledge that I have received, read, or have had read to me, the General Release of Liability Agreement, the Housing Authority, the Specific Releases Form, the HOR Handbook, and general rules and regulations. I have been given the opportunity to review this application, and all other agreements hereto, with legal counsel of my choosing. I have executed the General Release Agreement and Housing Agreement voluntarily, free of duress, coercion, or undue influence.

\_\_\_\_\_  
Applicant Signature/Date

\_\_\_\_\_  
Witness Signature/Date