ReUnite

RESIDENTIAL COUNSELING CENTER

APPLICATION FOR ADMISSION

GENERAL INFORMATION

Print Name: ____
(First) (Middle) (Last)

Maiden Name/Other Names/Nicknames/Aliases: ______________________________

Present Address: ____
(Street)

____
(City/State) (Zip)

Email: ____

Date Moved To This Address: _______ / _______

Responsible Person For Above Address: ___________________________________

Relationship: ____________________ Contact #: ____________________

Emergency Contact Name: ____

Address: ____

Relationship: ____________________ Contact #: ____________________

PERSONAL INFORMATION

DOB: ______/______/______ Age: ______ Weight: _______ Height: ______ Eye Color: ________

Social Security Number: ____

Race: ☐ White ☐ Black ☐ Hispanic ☐ Indian ☐ Other ___________

Do You Have A Valid Driver License? ☐ Yes ☐ No

Driver's License Number: ________________________________ State: ____________

If no, how much is the reinstatement fee? $ _________

What are the steps to reinstate? ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How long has this been your marital status? __________

How many times have you been married? __________

Spouse's Full Name: ____

Address: ____

Contact #: ______________________________ Spouse Supportive: ☐ Yes ☐ No

Do You Have the Following? (If yes, please give copies to Intake Staff)

Social Security Card ☐ Yes ☐ No

Birth Certificate ☐ Yes ☐ No

Driver's License or State ID ☐ Yes ☐ No

Insurance Card ☐ Yes ☐ No

Military Service ☐ Yes ☐ No

Branch ____________________ Type of Discharge ____________________

Do You Have Any Military Obligations At This Time? ☐ Yes ☐ No

High School Diploma ☐ Yes ☐ No

GED or HiSet ☐ Yes ☐ No

College ☐ Yes ☐ No

Name of College ____

Highest Grade Completed ____

Are You Interested in Pursuing Higher Education? ☐ Yes ☐ No

Area of Interest ____

CHILD(REN) INFORMATION

How many children do you have? ________ How many do you have custody of: ________

Do you want to regain full custody of your child(ren)? ☐ Yes ☐ No How many? _______

Who currently has custody of your child(ren)? ______________________________

CHILD ONE

Child's Name ____________________

Child's DOB ____________ Child's Age ____________ ☐ Male ☐ Female

Child's School ____________________ Grade ____________

Guardian Name ____________________

Address ____________________

Relationship ____________________ How Long? ________

Is the above listed person willing to support you in regaining custody of your child(ren)? ☐ Yes ☐ No

Is the above listed person willing to participate in family counseling offered by ReUnite Ministries? ☐ Yes ☐ No ☐ Unsure

Does this child have an active case with DCS? ☐ Yes ☐ No

Case Manager Name ____________________

Do you give the staff of ReUnite permission to be involved in the details of the case?

(Sign separate release form as part of Pre-Admission requirements) ☐ Yes ☐ No

Do you pay child support on this child? ☐ Yes ☐ No $________ per ______

Are you court ordered to pay child support? ☐ Yes ☐ No $________ per ______

Are you behind on child support? ☐ Yes ☐ No $____________________

Do you have scheduled visitations with this child? ☐ Yes ☐ No

If yes, must these visits be supervised? ☐ Yes ☐ No

Who are the other people (family or friends) involved in caring for this child?

Is this child on any medication? ☐ Yes ☐ No

Does this child have any mental health conditions? ☐ Yes ☐ No

Is this child under the care of a therapist? ☐ Yes ☐ No

Does this child have any disabilities? ☐ Yes ☐ No

Does this child have a criminal record/history? ☐ Yes ☐ No

CHILD TWO

Child's Name ______________________________

Child's DOB ____________ Child's Age ____________ ☐ Male ☐ Female

Child's School ______________________________ Grade ____________

Guardian Name ______________________________

Address ______________________________

Relationship ______________________________ How Long? ________

Is the above listed person willing to support you in regaining custody of your child(ren)? ☐ Yes ☐ No

Is the above listed person willing to participate in family counseling offered by ReUnite Ministries? ☐ Yes ☐ No ☐ Unsure

Does this child have an active case with DCS? ☐ Yes ☐ No

Case Manager Name ______________________________

Do you give the staff of ReUnite permission to be involved in the details of the case?

(Sign separate release form as part of Pre-Admission requirements) ☐ Yes ☐ No

Do you pay child support on this child? ☐ Yes ☐ No $________ per ______

Are you court ordered to pay child support? ☐ Yes ☐ No $________ per ______

Are you behind on child support? ☐ Yes ☐ No $____________________

Do you have scheduled visitations with this child? ☐ Yes ☐ No

If yes, must these visits be supervised? ☐ Yes ☐ No

Who are the other people (family or friends) involved in caring for this child?

Is this child on any medication? ☐ Yes ☐ No

Does this child have any mental health conditions? ☐ Yes ☐ No

Is this child under the care of a therapist? ☐ Yes ☐ No

Does this child have any disabilities? ☐ Yes ☐ No

Does this child have a criminal record/history? ☐ Yes ☐ No

CHILD THREE

Child's Name ____

Child's DOB ____________ Child's Age ____________ ☐ Male ☐ Female

Child's School ______________________________ Grade ____________

Guardian Name ____

Address ____

Relationship ________________________ How Long? ________

Is the above listed person willing to support you in regaining custody of your child(ren)? ☐ Yes ☐ No

Is the above listed person willing to participate in family counseling offered by ReUnite Ministries? ☐ Yes ☐ No ☐ Unsure

Does this child have an active case with DCS? ☐ Yes ☐ No

Case Manager Name ____

Do you give the staff of ReUnite permission to be involved in the details of the case?

(Sign separate release form as part of Pre-Admission requirements) ☐ Yes ☐ No

Do you pay child support on this child? ☐ Yes ☐ No $________ per ______

Are you court ordered to pay child support? ☐ Yes ☐ No $________ per ______

Are you behind on child support? ☐ Yes ☐ No $____________________

Do you have scheduled visitations with this child? ☐ Yes ☐ No

If yes, must these visits be supervised? ☐ Yes ☐ No

Who are the other people (family or friends) involved in caring for this child?

Is this child on any medication? ☐ Yes ☐ No

Does this child have any mental health conditions? ☐ Yes ☐ No

Is this child under the care of a therapist? ☐ Yes ☐ No

Does this child have any disabilities? ☐ Yes ☐ No

Does this child have a criminal record/history? ☐ Yes ☐ No

(Use separate sheet to list additional children)

SUBSTANCE ABUSE HISTORY

Have you ever used drugs or alcohol? ☐ Yes ☐ No How long? ______________

Explain the details of your drug or alcohol use:

____

____

What is your drug of choice? ____________ How long have you been using it? ________

Do you consider yourself addicted? ☐ Yes ☐ No

When was the last time you used? ______ Can you pass a drug test now? ☐ Yes ☐ No

Please explain how you started using and who you started using with:

____

____

____

____

I depend on substance(s) for the following reasons (check all that apply):

☐	to cope with life	☐	for pleasure	☐	to escape reality
☐	to be a part of the crowd	☐	mental illness (undiagnosed)	☐	other:

What is your longest clean time since you been using? ______________________________

Did your parents use in the past? ☐ Yes ☐ No

Do your parents currently use? ☐ Yes ☐ No

Did you ever use with your parents? ☐ Yes ☐ No If yes, with whom? _____________

Have you ever been to treatment/rehab before now? ☐ Yes ☐ No How many? ______

Faith based: ☐ Yes ☐ No Insurance based: ☐ Yes ☐ No

List the most recent treatment facility or program you have attended:

Name of Program/Facility: ____

Address: ____

Contact #: ____

Have you ever been homeless? ☐ Yes ☐ No If yes, how long? ________

What were the circumstances that causes you to become homeless?

____

____

CRIMINAL

Have you ever been arrested? ☐ Yes ☐ No How many times? ________________

Date ____________ Convicted? ☐ Yes ☐ No

Charges ____

Sentence ____

Time Served ____

Date ____________ Convicted? ☐ Yes ☐ No

Charges ____

Sentence ____

Time Served ____

Date ____________ Convicted? ☐ Yes ☐ No

Charges ____

Sentence ____

Time Served ____

(Use separate sheet to list additional charges)

Do you have any felony charges? ☐ Yes ☐ No If yes, for what?

Any pending charges? ☐ Yes ☐ No If yes, for what?

Are you currently on probation? ☐ Yes ☐ No If yes, for how long? _______

Time remaining: __________ Probation Fees: $__________

Behind? ☐ Yes ☐ No How much: $ ____________

How do you report? ☐ in person ☐ by mail ☐ phone

How often: ____

Probation Officer Information

Name: ______________________________ Contact #: ________________

Address: ____

Lawyer Information

Name: ______________________________ Contact #: ________________

Address: ____

Have you ever been in prison? (Provide additional info) ☐ Yes ☐ No

When: ________________ Where: ________________

Have you ever been in county jail? (Provide additional info) ☐ Yes ☐ No

When: ________________ Where: ________________

Are you required by the courts to complete a program? ☐ Yes ☐ No

If yes, provide the following information:
Judge Information

Name: ____ Contact #: ______________________

Charges: ______________________________________ City/State: ______________________

MEDICAL

Rate your current health condition: ☐ excellent ☐ good ☐ fair ☐ poor

Do you have any current condition that would prevent you from working? ☐ Yes ☐ No

Do you have any current condition that would prevent you from participating in a fitness program? ☐ Yes ☐ No

Do you have concerns about your health? ☐ Yes ☐ No
If yes, please explain:

____

____

Date of last menstrual cycle: ________________________

Are you pregnant? ☐ Yes ☐ No
If yes, how many months? _____ Do you have any complications? ☐ Yes ☐ No
If yes, explain: ____

Date of last OBGYN exam? __________ Do you have any STD's? ☐ Yes ☐ No

Do you have any diseases? ☐ Yes ☐ No Medical handicap? ☐ Yes ☐ No

Have you been hospitalized in the past year? ☐ Yes ☐ No
If yes, explain: ____

Do you have a doctor? ☐ Yes ☐ No If yes, please provide the following information:

Doctor Name: ______________________________________ Contact #: __________________

Name of Practice: ____________________________________ City: ______________________

(Use separate sheet to list additional doctors)

Do you have Insurance: ☐ Yes ☐ No

If yes, primary provider? ____________________ Secondary provider? _____________________

Do you have any allergies? ☐ Yes ☐ No If yes, explain: _________________________

Have you ever been professionally diagnosed with a mental illness? ☐ Yes ☐ No
If yes, explain: ____

Have you ever been treated for a mental illness? ☐ Yes ☐ No
If yes, when? ___________ Where? ____________________ Diagnosis? ______________________

Do you think you have a current mental illness that needs to be treated? ☐ Yes ☐ No
If yes, explain: ____

List any medications that you are currently taking:

MEDICINE	DOSE	Rx DATE	QTY	PHYSICIAN	REASON

(Use separate sheet to list additional medications)

Are any of these medications a narcotic? ☐ Yes ☐ No If yes, which one(s)? ____________

List any medication you should be taking but are not currently: _________________________

Explain: ____

Do you have problems taking medications as prescribed? ☐ Yes ☐ No

Have any of these medications become addictive? ☐ Yes ☐ No

Which One(s): ____

Which medications do you prefer not to take? ____

EMPLOYMENT

Are up currently employed? ☐ Yes ☐ No

May we contact your employer? ☐ Yes ☐ No

Is your employer aware that you are seeking assistance? ☐ Yes ☐ No

Do you want to return to work for this employer? ☐ Yes ☐ No

Current Employer Information

Employer Name: ____ Date of Hire: ___________

Address: ____

Position: ____

Supervisor Name: ____________________________________Contact #: ___________________

List prior two places of employment:

Employer Name: ____ Start/End Date: ___________

Address: ____

Supervisor Name: __________________________________Contact #: _____________________

Position: ____

Reason for Leaving:____

Employer Name: ____ Date of Hire: ___________

Address: ____

Supervisor Name: __________________________________Contact #: ___________________

Reason for Leaving:____

Position: ____

Please list any specific skills, training and/or certifications you have:

____

____

FINANCIAL

Do you have someone that supports you financially in any way? ☐ Yes ☐ No

If yes, who: _____________________________ Relationship: ________________________
How much? _______ How often: _________ Transfer process: ____________________

Are you receiving welfare, SNAP, unemployment compensation, disability payments, worker's comp, alimony, VA benefits, or other payments? ☐ Yes ☐ No

If yes, please list from whom, how much, and how often:

____

____

____

Do you have outstanding debt? ☐ Yes ☐ No

If yes, please list below:

OWED TO	ADDRESS	AMOUNT	CONTACT #	PMT SCHEDULE

List any property you own including house, land and/or vehicles:

____

SPIRITUAL

Do you believe in God? ☐ Yes ☐ No ☐ Unsure

Have you ever committed your life to Jesus Christ as your personal Savior? ☐ Yes ☐ No ☐ Unsure

If yes, when? ________________

Have you ever attended church? ☐ Yes ☐ No

If yes, when and where? __________________________ How Often? _________________

Denomination Preference: ____

Have you ever been involved in the occult? ☐ Yes ☐ No

If yes, what was your practice: ____________________________________

Are you a member of any church or religion? ☐ Yes ☐ No

If yes, which one? ____

Do you have someone you consider your Pastor? ☐ Yes ☐ No

If yes, who? _________________________________ Contact #: ________________________

May we contact your Pastor for support? ☐ Yes ☐ No

COUNSELING ASSESSMENT (QUESTIONNAIRE)

In your own words, explain the current problem in your life and the reason(s) you want help.

____

____

____

What are your greatest needs, in order of priority?

____

____

____

Have you ever thought about ending your life or tried to end your life? ☐ Yes ☐ No
If yes, please explain:

____

____

Have you ever been associated with a gang or gang related activity? ☐ Yes ☐ No

Have you ever been abused: ☐ sexually ☐ physically ☐ emotionally
If yes, have you ever received treatment and/or counseling for the abuse? ☐ Yes ☐ No

Have you ever lost someone close to you to death? ☐ Yes ☐ No
If yes, who: __________________________________ When? ______________________

Briefly explain any other trauma you have experienced in your life that you feel has impacted you in a negative manner:

____

____

____

CERTIFICATION/AUTHORIZATION

My answers on this application and on any documents I provide are complete and true. I authorize ReUnite / RIO Revolution Church and its agents to verify any information related to my application or documents. I also authorize individuals, schools, employers, and law enforcement or government officials to freely release any information concerning my background, and hereby release any and all of them from liability for doing so. Should my application be accepted, I agree to submit a background check and to the policies and procedures of ReUnite / RIO Revolution Church.

By signing this form, I admit that the answers and information are true and accurate.

APPLICANT SIGNATURE: ____

APPLICANT PRINTED FULL NAME: ____________________________________DATE: ___________

INTAKE COORDINATOR SIGNATURE: ____

INTAKE COORDINATOR: ____DATE: ___________

ADDITIONAL INFORMATION/NOTES