Having the Courage to Change

A ministry of City Gospel Mission

Program Application

Date: _____ Prison ID#: _____

GENERAL INFORMATION

Personal Information		
Name	Aliases	
Race/Ethnicity	Date of Birth	
SS#	Driver's License #	
Current Address		Length of Time
City State ZIP		
Previous Address		Length of Time
City State ZIP		
Phone	Message Phone	
Medicaid#	Religious Preference	
Church Home		Length of Time

Marital Status	
o Single (Never Married)	
o Married	How Long
o Separated	How Long
o Divorced	How Long
o Widowed	How Long

Children		
Name	Date of Birth	Current Place of Custody
1.		
2.		
3.		
4.		
5.		

Emergency Contact	
Name	Relationship
Address	
Home Phone	Work Phone
Pager	Cellular Phone

FAMILY HISTORY

Parents' Name	Date of Birth	How Often Visited/Deceased
1.		
2.		
List Siblings (Brothers & Sisters)		
1.		
2.		
3.		
4.		
5.		
Significant Support Person		
1.		
2.		
3.		

HOUSING *(Check One)*

o Living Independently	How Long
o Living with Parents	How Long

FINANCIAL

Current Income (Indicate amount for each. Use zero if you receive no income. Do not leave blank.)	
AFDC	Social Security
Food Stamps	Salary
SSI	Worker's Comp

Current Expenses (Indicate amount for each. Use zero if you no expenses. Do not leave blank.)	
Rent	Storage
Child Support	Other

Money Management
How well do you manage your money?
o I do it independently and am not in debt.
o Someone assists me to get my bills paid on time.
o I can't do it at all and as a result I am in debt.

MEDICAL HEALTH

1. Do you currently have any health problems that require on-going treatment (surgery, medication, physical therapy…)? o Yes o No
   If Yes, please indicate any **medical conditions / diagnosis** that you have:

   _____ _____
   _____ _____
   _____ _____

Please list any medications you are currently taking:

Name of Medication	Dosage	Purpose of Medication	Outcome/Response of Treatment	Side Effects

2. Have you been hospitalized for medical problems in the past 2 years? o Yes o No

Name of Institution	Dates of Treatment	Name of Physician who administered treatment	Outcome/Response of Treatment

Does HTCTC have permission to contact the institution/physician to coordinate treatment?
Yes No

MENTAL HEALTH

11. Have you received mental health services from any of the following?

Hospitals	o Yes	o No
Drug & Alcohol treatment programs	o Yes	o No
Residential programs	o Yes	o No
Transitional programs	o Yes	o No

12. Have you ever seen a counselor, psychiatrist, or physician for mental or emotional reasons (one time or ongoing)?
Yes o No

Name of Institution	Dates of Treatment	Name of Physician who administered treatment	Outcome/Response of Treatment

Does HTCTC have permission to contact the institution/physician to coordinate treatment?

Yes No

13. Are you currently taking prescribed medication for mental health or emotional reasons?
o Yes o No

If yes, please list the following information:

Name of Medication	Dosage	Prescribing Physician	Outcome/Response of Treatment	Side Effects

Does HTCTC have permission to contact the institution/physician to coordinate treatment?
Yes No
o

SUBSTANCE ABUSE HISTORY

3. How many cigarettes do you smoke per day?
4. Please circle which substances used and how often?

Alcohol	Daily	1-3 times a week	monthly	2-4 times a year	never
Marijuana	Daily	1-3 times a week	monthly	2-4 times a year	never
Pills	Daily	1-3 times a week	monthly	2-4 times a year	never
Crack Cocaine	Daily	1-3 times a week	monthly	2-4 times a year	never
Heroin	Daily	1-3 times a week	monthly	2-4 times a year	never
Other	Daily	1-3 times a week	monthly	2-4 times a year	never

5. When was the last time you used drugs? Alcohol?
6. What is your drug of choice?
7. Do you continue to use any of these substances despite negative consequences (i.e. loss of job or relationships with friends and family?) Yes No

Please indicate how drugs have impaired your life:

_____
_____
_____
_____
_____

8. Have you experienced any symptoms of withdrawal using any of the substances listed above? Yes No If so, please list

_____
_____
_____

9. Circle the number which best describes your level of addiction.

5	4	3	2	1
I am definitely addicted	I am probably addicted	I don't know if I am addicted	I am probably not addicted	I am definitely not addicted

10. Have you ever received in- or outpatient treatment for drug or alcohol addiction?
o Yes o No

If yes, please list the following information:

Name of Institution	Dates of Treatment	Name of Physician who administered treatment	Outcome/Response of Treatment

Does HTCTC have permission to contact the institution/physician to coordinate treatment?
Yes No
o

EDUCATION

1. What was the last grade that you fully completed?		
2. Do you have a:		
GED	o Yes	o No
High School diploma	o Yes	o No
Trade School diploma	o Yes	o No
College diploma	o Yes	o No

LEGAL

1. Do you have any outstanding warrants? o Yes o No
2. Are you currently on probation or parole? o Yes o No
3. Do you have any pending court cases? o Yes o No
4. Have you been recently or are you currently incarcerated? Yes No
   Please list all offenses: _____
   _____
   _____
5. List any arrests and the outcomes in the past five years.
   _____
   _____
6. Have you ever been convicted of a sex offence against a child? Yes No
7. What is your prospective release date?
8. Who is your case manager and what is their phone number? _____
   _____
9. Who is your chaplain and what is their phone number? _____
   _____

SOCIAL SERVICES

1. Have you ever been involved with Social Services for reasons other than financial assistance? o Yes o No
2. Are you currently involved with Social Services for reasons other than financial assistance? o Yes o No

I understand that if I am accepted as a participant in this ministry, that falsification or absence of any information on this form is grounds for dismissal. I also understand that by signing this form I am giving HTCTC permission to contact the institutions listed in this form to coordinate treatment. I authorize HTCTC to release and/or receive copies of information concerning my treatment or hospitalization.

_____ _____

Signature Date

Please return the completed application to:

City Gospel Mission
c/o Having the Courage to Change/Women's Ministry
1805 Dalton Ave., Cincinnati, Ohio 45214
(513) 345-1094

Contact will be made in 72 hours. Please indicate a telephone number
_____ and a time _____ you can be reached.

We look forward to meeting with you.

Lucretia Bowman, Director