

TRANSFORMATIONS Ladies' Recovery Program Application 1200 Arkansas Road, West Monroe, LA 71291 Phone: 318.582.5757	Date of Application		
	Home (circle preference)		

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Applicant's Name		Social Security Number	
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Phone Number(s)		Date of Birth	
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Current Address		City	State	Zip
E-Mail Address				

Entrance Date	<input type="checkbox"/> Probation <input type="checkbox"/> Parole <input type="checkbox"/> Sex Offender <input type="checkbox"/> Pending Charges (Explain Below)			
	Date of Release /		Parole Officer:	Case Worker:
	_____		_____	_____
Phone #:		Phone #:		

Explain Any Pending Legal Issues and upcoming court dates in detail:

Entry fee Yes No \$150 Non-Refundable	Comments Regarding Current Financial Situation
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ADDICTION INFORMATION

Addict Yes No	Date Last Used (MM/DD/YYYY)	1 st Drug of Choice	How long used?
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Alcoholic Yes No	Date Last Used (MM/DD/YYYY)	2 Drug of Choice	How long used?
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EMERGENCY CONTACT INFORMATION

Name of Relative Not Currently Living with You	Phone Number	Relationship
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Mailing Address	City	State	Postal Code
Email Address			

SPOUSE INFORMATION, IF MARRIED

Name	Are you able to talk with your spouse? Yes No
Work Phone Number	Cell Number

MEDICAL INFORMATION

Current Medical Condition (Explain)		
Are you pregnant? Yes No	Current Medications	4.
	1.	5.
If pregnant, how many weeks?	2.	6.
	3	7.

VEHICLE INFORMATION

Own Vehicle	License Plate Number	Is Vehicle Insured:	Current Driver's License	Driver's License Number
Yes No		Yes No	Yes No	

CHILDREN'S NAMES IF OVERNIGHT PRIVILEGES ARE DESIRED

Name & Age	Name & Age
Foster Care	With Relative
Yes No	Yes No

SIGNATURE AUTHORIZATION

With my signature below, I authorize the verification of all information I have provided on this application.	
Signature	Date

DRUG AND ALCOHOL POLICY

We have a no tolerance policy for drugs and alcohol. When you sign this agreement, you agree to the following conditions:

If you relapse which includes drugs, alcohol and/or sexual violations you will have two choices:

1. Enter a reputable rehabilitation center and get clean for 30 days, then come back and try again. Or enter our restart program.
2. Or leave the premises.

These are the only two choices you will have. Our goal is to prepare women to go back into the community healthy and ready to fulfill God's purpose for their lives. We strive to live with integrity and help women return to their families after completing this program and become productive members of society.

We pray that you choose to change your life through transformation. God bless you!

I have read, understood and agree to the terms of Transformations Ladies' Recovery Program:

Print Name _____

Signature _____

Date _____

House Manager _____

Date _____

Program Director _____

Date _____

RELEASE OF CRIMINAL CONVICTION RECORDS

I do hereby authorize Transformations Ladies Recovery Program to examine any and all criminal records and arrests on file in the parishes/counties in the state of which I have convictions. In doing so, I understand that I am waiving my right of confidentiality concerning my criminal history to the directors and/or managers of Transformations Ministries alone. I further agree to, and understand that, Transformations will perform an extensive background check as well as a motor vehicle history report to investigate any information given in the application.

I have convictions in the following parishes/counties and states:

Parish/County, State and Conviction

Parish/County, State and Conviction

Parish/County, State and Conviction

Print Applicant's Name _____

Driver's License/ID Number _____

Social Security Number _____

Street Address _____

City _____ State _____ Zip _____

Signature _____ Date _____

DRUG SCREEN AUTHORIZATION AND CONSENT

I authorize and give full permission to have Transformations Ladies Recovery Program and/or their selected physician send a specimen of my urine and/or blood for a screening test for the presence of illegal drugs, alcohol, tobacco or prescription medication taken without a prescription.

I will hold all parties concerned harmless, meaning I will not sue or hold responsible for any alleged harm to me or interfering with my obtaining a job or continuing employment due to not submitting to the tests or as a result of the report of the test. This includes but is not limited to possible clerical or laboratory error.

I understand that Transformations will require a drug screen test at random. My refusal to drug test or a positive result will be grounds for termination from the Transformations Ladies Recovery Program.

Print Name _____

Signature _____

Date _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient/Client Name _____

Date of Birth _____

The above-named person must indicate when this authorization is to expire:

- | | |
|---|---|
| <input type="checkbox"/> When information is received | <input type="checkbox"/> In one year |
| <input type="checkbox"/> In six months | <input type="checkbox"/> In three years |
| <input type="checkbox"/> On specific date _____ | |

The person named above is or has been a patient of:

Name of person, provider or facility _____

Address _____

Phone _____ Fax _____ Email _____

The person named above hereby authorizes _____ to

- | | |
|--|---|
| <input type="checkbox"/> Request health information from | <input type="checkbox"/> Send health information to |
| <input type="checkbox"/> Discuss health information with | |

The person named above authorizes information to be requested or released by representatives of:

Transformations Ladies Recovery Program and/or Debbie Johnson, RN

1200 Arkansas Road

West Monroe, LA 71291

Phone: 318.582.5757

Fax: 855.299.4333

Mobile: 318.376.2895

Scope

- | | |
|--------------------------|---|
| <input type="checkbox"/> | All information regarding assessment, diagnosis and treatment of patient's condition, concern or disease (specify): _____ |
| <input type="checkbox"/> | All information regarding care received by patient between the dates of:
Starting Date _____ Ending Date _____ |
| <input type="checkbox"/> | Other information (specify): _____ |

Authorization

Printed name of Patient/Client _____ Date _____

Signature of Patient/Client _____

Signature of Witness _____ Date _____

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

Initial	Date	Treatment	From	To
_____	_____	Alcohol or Drug Abuse	_____	_____
_____	_____	Mental Health	_____	_____
_____	_____	HIV/AIDS Status	_____	_____

The above-named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to the clinic, facility or caretaker. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be released.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for entrance into the Transformations Ladies Recovery Program.

FAMILY CONTACTS

Name _____

Relationship _____

Phone Number _____

Email Address _____

Name _____

Relationship _____

Phone Number _____

Email Address _____

Name _____

Relationship _____

Phone Number _____

Email Address _____

VISITORS LIST

Only ten people can be on a resident's visitors list. Each visitor must be interviewed and approved by the Transformations program director(s) and/or house manager before any visit. Each visitor must also attend a Visitor's Orientation session held at White's Ferry Road Church at 9:00am (during Bible class) on the second Sunday of each month in the A-Wing Prayer Room. Family visits will take place after church in the White's Ferry Road Outreach Center from 11:30am to 1:00pm on the same second Sunday. All requests for visits must be made in writing to the house manager and program directors at least seven days in advance. Turning in a request does not result in automatic approval.

1. Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers _____
Email Address _____

2. Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers _____
Email Address _____

3. Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers _____
Email Address _____

4. Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers _____
Email Address _____

5. Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers _____
Email Address _____

6. Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers _____
Email Address _____

7. Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers _____
Email Address _____

8. Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers _____
Email Address _____

9. Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers _____
Email Address _____

10. Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Phone Numbers _____
Email Address _____

TRANSFORMATIONS MINISTRIES
RESIDENT INTAKE INVENTORY

NAME _____ **DATE** _____

PANTS _____

ATHLETIC/SWEAT PANTS _____

SHORTS _____

CAPRIS _____

SKIRTS _____

DRESSES _____

SHIRTS _____

T-SHIRTS _____

TANKS/CAMIS _____

SWEATERS _____

JACKETS/COATS _____

PAJAMAS/GOWNS _____

ROBES _____

BATHING SUITS (1 PIECE ONLY) _____

BELTS _____

SCARVES _____

HATS/CAPS _____

GLOVES/MITTENS _____

SHOES _____

BOOTS _____

ATHLETIC SHOES _____

SLIPPERS _____

SANDALS/FLIP-FLOPS _____

UNDERWEAR _____

BRAS _____

SOCKS _____

TIGHTS/HOSE _____

LUGGAGE _____

BACKPACK _____

PURSES _____

BOOKS _____

BIBLES _____

ALARM CLOCK/RADIO (ONLY 88.7) _____

FAN _____

STAMPS _____

STATIONERY _____

BINDERS _____

NOTEBOOKS/JOURNALS _____

PEN/PENCIL _____

ART SUPPLIES _____

PHONE/CALLING CARD _____

HAIR DRYER _____

CURLING IRON _____

STRAIGHTENER _____

HAIRBRUSH/COMBS _____

SHAMPOO/CONDITIONER _____

HAIRSPRAY _____

OTHER HAIR PRODUCTS _____

FACIAL CLEANSER _____

FACIAL TONER/MOISTURIZER _____

DISPOSABLE RAZORS _____

SHAVING LOTION _____

NAIL CLIPPERS/TWEEZERS _____

FEMININE HYGIENE PRODUCTS _____

TOOTHBRUSH/TOOTHPASTE _____

MOUTHWASH (ALCOHOL FREE) _____

DEODORANT _____

BODY WASH/SOAP _____

BODY/HAND LOTION _____

SHOWER CADDY _____

MIRROR _____

MAKEUP ITEMS _____

TISSUE _____

SCISSORS _____

SEWING KIT _____

PILLOW _____

SHEET SETS _____

BLANKET _____

COMFORTER/COVER _____

DRIVER'S LICENSE/ID _____

SOCIAL SECURITY CARD _____

SNAP CARD (FOOD STAMPS) _____

JEWELRY (ITEMIZE) _____

PRESCRIPTION MEDICINE (ITEMIZE) _____

OVER THE COUNTER MEDICINE (ITEMIZE) _____

THE FOLLOWING WILL BE HELD BY THE HOUSE MANAGER UNTIL THE RESIDENT HAS BEEN CLEARED TO USE:

MOBILE PHONE _____

TABLET _____

LAPTOP _____

CASH _____

CREDIT/DEBIT CARDS (ITEMIZE) _____

SHIRTS MUST COVER THE STOMACH AND BACK, TANK TOPS OR SPAGHETTI STRAP TOPS MAY BE WORN UNDER SHIRTS ONLY, NOT ALONE; NO LOW-CUT SHIRTS OR DRESSES MAY BE WORN; SHORTS MUST HAVE A MINIMUM OF A 6" INSEAM; SKIRTS AND DRESSES MAY BE NO MORE THAN 2" ABOVE THE KNEE.