



VA GRANT & PER DIEM PROGRAM
APPLICATION/REQUIREMENTS for ADMISSION

PURPOSE: Our primary goal is to facilitate a stable environment that gives Veterans an opportunity to break the cycle of homelessness and addiction as they rebuild their lives and re-enter society as an active contributing member by achieving residential stability, increasing their skill level, and obtaining greater understanding of their strengths and purpose.

PROGRAM: Harvest House provides an opportunity for a new life conforming to right moral standards in a home-like, faith-based environment.

COST: Per Diem funds cover cost of housing, treatment, basic food items, and access to public transportation.

ACCOUNTABILITY: Residents develop a character of respect, integrity, and humility as they honor the program structure of Harvest House; i.e. *Progressive Four Phase Program, Daily Schedule, House Rules, Cause for Disciplinary Discharge, etc.* as well as staff directives.

GUIDELINES:

- A. Commit to nine months of residency with the goals of independent & sober living.
- B. Honor House Rules and staff directives with diligence and respect.
- C. Break from dysfunctional people, places, and things that brought you to Harvest House.
- D. Agree to a search of your person and possessions upon arrival, or at anytime thereafter, while a resident of Harvest House. Agree to random urinalysis and upon request.
- E. Resident will set up escrow account with the purpose of saving towards independent living.
- F. Harvest House reserves the right to discharge any resident at anytime for not complying with the Code of Conduct or Program Description. If discharged, agree to leave without disruption to staff or other residents.

If you share the perspective offered by Harvest House, you are welcome to make official application for admission by signing below. Your signature denotes that you have voluntarily and free of coercion, read and agree to submit to the authority of Harvest House as referenced in this document. Upon the review of your completed application and the available bed space you will be notified as to acceptance. To contact HHTC call (941) 953-3154.

Please remember to enclose the proper release form from your contact person (lawyer, case worker, probation officer, Chaplain, counselor, family member, friend, other).

Applicant's Name (PRINT): _____

Applicant's Signature: _____ Date: _____

Anticipated Admission Date: _____ Time: _____

Staff Approval: _____ Date: _____

IDENTIFICATION INFORMATION

Date: _____

First Name: _____ Last Name: _____ M.I.: _____

Currently Homeless: Y N If No, Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

SS#: _____ Sex: _____ Citizenship: _____

Age: _____ D.O.B.: _____ Marital Status: _____ Race: _____

Living with: _____ Relationship: _____

Spouses Name: _____ Address: _____

No. of Children: _____ Are you a veteran? _____

Level of Education: _____

Do you have a FL I.D./D.L.: Y N Birth Certificate: Y N SS Card: Y N

What languages do you speak?: _____

Give a one word description of your life now: _____

FINANCIAL ASSISTANCE

Please circle the following financial assistance you are currently receiving and the amount per month:

SSI \$_____.____ Other? _____ \$_____.____

SSDI \$_____.____

Food Stamps \$_____.____

WIC \$_____.____

HUD \$_____.____

Cash Assistance \$_____.____

If you are unable to pay your program fee who will be your guarantor to insure that it is paid? _____

PREVIOUS COUNSELING HISTORY

Have you ever gone for counseling?: _____ When?: _____

Where?: _____

For what?: _____

Are you currently receiving help from another professional?: _____ Who?: _____

Have you ever attempted suicide?: _____ Has anyone in your family?: _____

Has anyone in your family ever been diagnosed mentally ill?: _____

CRIMINAL JUSTICE SYSTEM

Charges Pending: _____

City: _____ Judge: _____ Next hearing date: _____

Are you n Probation or Parole? (circle one) _____ Date of Sentencing: _____

Probation Officer: _____ Phone No. of PO: _____

Address of PO: _____

Terms of Probation/Parole: _____

Ever violated?: _____ When?: _____

Prior Criminal History:

Date	City	Charge	Disposition

Attorney/Public Defender's Name: _____

Address: _____

Appointed or Retained (circle one) _____

Have you ever been required to register as a sex offender? _____

If yes, when was it and what were the charges? (use space provided below)

SUBSTANCE ABUSE HISTORY

Check all that you have abused and when:

DRUG	USED		HOW OFTEN	HOW LONG
	<u>Past</u>	<u>Present</u>	<u>Frequency</u>	<u>Duration</u>
<u>Alcohol</u>	_____	_____	_____	_____
<u>Marijuana</u>	_____	_____	_____	_____
<u>Hallucinogenic</u>	_____	_____	_____	_____
<u>Barbiturates</u>	_____	_____	_____	_____
<u>Amphetamine</u>	_____	_____	_____	_____
<u>Methamphetamine</u>	_____	_____	_____	_____
<u>Heroin</u>	_____	_____	_____	_____
<u>Methadone</u>	_____	_____	_____	_____
<u>Cocaine</u>	_____	_____	_____	_____
<u>Opiates</u>	_____	_____	_____	_____
<u>K2/Spice</u>	_____	_____	_____	_____
<u>Other?</u> _____	_____	_____	_____	_____

Have you used alcohol in the last 7 days?: _____ When?: _____

Is alcohol your drug of choice?: _____

Have you used a drug in the last 7 days?: _____ What?: _____ When?: _____

What is your drug of choice (excluding alcohol)?: _____

QUESTIONS:

Do you feel alcohol/drugs are a problem for you? Y N

Have you ever been arrested under the influence/high? Y N

Have you ever needed more alcohol/drugs to get the same affect? Y N

Has anyone ever complained about your behavior? Y N

How old were you when you first noticed your problem? _____

Have you ever tried to cut down or stop using alcohol/drugs? Y N

When?: _____

EMPLOYMENT HISTORY

Are you currently employed? _____ If yes, where?: _____

Position/Title: _____ Name/Number of Supervisor: _____

LIST YOUR 3 MOST RECENT JOBS:

Employer	Position	Time Frame (dates)	Reason for leaving	Attitude toward job

What kind of work are trained to do?: _____

What kind of work are you interested in?: _____

YOUR HEALTH AND MEDICAL INFORMATION

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone #: _____

Medical Insurance: Yes or No Policy #: _____

When did you last see a Doctor? _____ For What? _____

Have you ever used needles? _____

Have you ever participated in homosexual activity? _____ When? _____

Have you had an HIV test? _____ When? ____/____/____ Result?: _____

Have you had any other S.T.D. tests? _____ When? ____/____/____ Result?: _____

Treatment history? _____

Is it possible that you are pregnant?: _____

Have you taken any medication in the last year? _____

What: _____ When: _____

** Please list all medication you are currently taking:

Are you on a special diet? _____ If so, what? _____

Please list any current allergies or physical complaints/problems: _____

Check symptoms you **currently** have:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Upset stomach |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Excess fatigue |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> DT's | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Rapid weight loss | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> VD or Herpes | <input type="checkbox"/> Back problems |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> HIV (AIDS) | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Open sores | <input type="checkbox"/> Bone or joint pain | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Chest pain | <input type="checkbox"/> other |

Explain above symptoms:

Have you ever been diagnosed with a mental illness? What? _____

When? _____ What medication was prescribed? _____

How did you hear of Harvest House Transitional Centers? _____

List 3 goals you hope to achieve by participating in this program:

1) _____

2) _____

3) _____

Additional Notes:

All questions and sections must be completed for this application to be processed. Please return your application Admissions at 209 N Lime Ave Sarasota, FL 34237, via fax (941) 954-2349, scan & email to info@harvesthousecenters.com, or in person.

Thank you for your interest in our program. Your application will be processed within 48 hours from the time we receive it. If you do not here from our Admissions department regarding your application please feel free to contact us.

"Your Freedom Starts Now"