HOPE CENTER INDY

PROGRAM SUMMARY

The resident program consists of five phases, each lasting 90 days. The days in each phase are approximate as each resident is individually assessed as to promotion within the program. Residents do not pay any amount of money for participation in the program. Please email the completed form to our program director, Desiree Burnett at dburnett@hopecenterindy.org.

Phase Focuses:

- Phase I: Introduction & Acclimation
- Phase II: Education
- Phase III: Employment
- Phase IV: Sustainability
- Phase V: Reintegration

Requirements:

- Attend 1-2 meetings weekly (AA, NA, HA, CR)
- Attend 1 financial literacy class weekly
- Attend 3 education classes per week (if seeking GED)
- Attend 1 trauma therapy session weekly
- Attend 1 worship service weekly
- Attend 1 church service weekly
- Attend 1 Bible study weekly

5 Pillars Program for Goal Achievements:

- Spiritual
- Career
- Wellness
- Financial
- Relational

The following are policies that may be of interest to you. Please ask about any area you would like explained further.

- Smoking Policy
- House Chores
- Care Packages
- Visitations
- Medication
- Transportation

HOPE CENTER INDY

HOPE CENTER INDY APPLICATION

Name: _____ Age: _____ DOB: _____ SSN: _____

Phone #: _____ Sobriety Date: _____ Longest Sobriety: _____ When: _____

Photo ID: _____ Gender: _____ Ethnic Background: _____ Marital Status: _____

# of Children: _____ Name(s)/Age(s)/Gender(s): _____

_____

Where Have You Been Staying: _____ Address/City/State/Zip: _____

Where are your children staying: _____ Do you have contact? _____

Do you have a DCS Case? _____ If yes, DCS contact info: _____

Do you receive: SNAP (Food Stamp) Benefits: _____ TANF Benefits: _____

Medical Insurance

Do you have Medical insurance? _____ If yes: Insurance Provider: _____

Insured Name: _____ Insured's D.O.B.: _____

Group #: _____ Insurance ID#: _____ Payer ID#: _____

Benefit Verification Phone: _____ Claim Submission Phone: _____ Copy of Card: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Address: _____

Referral: Who told you about Hope Center Indy?

Name: _____ Organization: _____

How can Hope Center Indy help you? _____

_____

_____

HOPE CENTER INDY

Alcohol/Drug Use History

Drug choice & age of 1st use: 1st _____, Age _____ / 2nd _____, Age _____ /3rd _____, Age _____

What is your current frequency of use? _____

How do you use? _____ Have you ever used or shared a needle? _____

Have you used any of the following (check all that apply): Alcohol _____ Heroin _____ Marijuana _____ Hallucinogens _____
Crack _____ Benzos _____ Opiates _____ Meth _____ Cocaine _____ Speed _____ Synthetics _____

Substance Abuse/Mental Health Treatment

Have you ever been diagnosed w/ a mental health disorder? _____ If yes, what was the diagnosis? _____

Were you actively using at the time of diagnosis? _____

List the following treatment centers you have been in:

Date	Program Name	Type of Program	Length of Treatment	Outcome of Treatment

Family History of Substance Abuse

Relative	Y	N	Notes
Mother			
Step-Mother			
Father			
Step-Father			
Brother(s)			
Sister(s)			
Aunts/Uncles			
Cousins			
Grandparents			

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Current Partner:

Name: _____

Address: _____

Phone #: _____

Length of Relationship: _____

Substance Use? _____

Former Relationships (5 Years Back):

Name	From	To	User

Foster Care:

Have you ever been in foster care? _____ If yes, how many times? _____ How old were you? _____

Physical/Emotional/Sexual Abuse History:

Have you been a victim of CHILDHOOD: Physical Abuse_____ Mental/Emotional Abuse_____ Sexual Abuse_____

Have you been a victim of rape? _____ If yes, when? _____

_____

Domestic Violence

Are you currently fleeing a domestic violence situation? _____ Have you ever been in a domestic violence situation? _____

If yes, who was the perpetrator and when did this occur? _____

_____

Suicidal Ideation

Have you ever attempted suicide? _____ # of attempts _____ When? _____ Method? _____

Do you currently have suicidal thoughts or feelings? _____

If yes, have you thought about how, when, or where this would occur? _____

_____

HOPE CENTER INDY

MEDICAL HISTORY & SCREENINGS

	Date	(+,-)
HIV		
HEP		
TB		
STD'S		

Blood type: _____ Last menstrual period: _____

Birth control: _____ Date of last physical exam: _____

Physician's name/clinic: _____

Are you currently under a physician's care? _____ If yes, for what condition: _____

_____

Do you have any medical and/or physical issues that need to be addressed? _____ If yes, what are they? _____

_____

What, if any, current medications are you taking? (Over the counter & prescriptions): _____

_____

Are you allergic to any food or medications? _____ If yes, what are they? _____

Do you have a special diet? _____ If yes, please explain: _____

Do you have any physical limitations that would not permit you to climb stairs? _____

Please check all that apply:

_____Diabetes _____ Hypertension (High blood pressure) _____ Hyperlipidemia (High cholesterol) _____Cancer

_____Smoking _____Obesity _____Asthma _____COPOD

Adverse Childhood Experience Study (ACE)*Circle one answer for each question. If yes, enter a 1 on the line. Total at the bottom.*

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often
   Swear at you, insult you, put you down or humiliate you?
   OR
   Act in a way that made you afraid that you might physically be hurt? Yes No _____

2. Did a parent or other adult in the household often or very often…
   Push, grab, slap, or throw something at you?
   OR
   Ever hit you so hard that you had marks or were injured… Yes No _____

3. Did an adult or person at least 5 years older than you ever…
   Touch or fondle you or have you touch their body in a sexual way?
   OR
   Attempt to actually have oral, anal, or vaginal intercourse with you? Yes No _____

4. Did you often or very often feel that…
   No one in your family loved you or thought you were important or special?
   OR
   Your family didn't look out for each other, feel close or support each other? Yes No _____

5. Did you often or very often feel that…
   You didn't get enough to eat, had to wear dirty clothes & had no one to protect you?
   OR
   Your parents were too drunk/high to take care of you or take you to a doctor? Yes No _____

6. Was your mother or stepmother…
   Often or very often pushed, grabbed, slapped or had something thrown at her?
   OR
   Sometimes, often or very often kicked, bitten, hit with a fist or something hard?
   OR
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife? Yes No _____

7. Were your parents ever separated or divorced? Yes No _____

8. Did you live with anyone who was a problem drinker/alcoholic or who used street drugs? Yes No _____

9. Was a household member depressed/mentally ill or attempt suicide? Yes No _____

10. Did a household member go to jail? Yes No _____

STAFF NOTES: _____

_____

STAFF USE ONLY: TOTAL ACE SCORE: _____

_____

_____

_____

_____

Please circle the most accurate answer under each statement:

1. I believe that my mother loved me when I was little.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

2. I believe that my father loved me when I was little.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it too.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

6. When I was a child, neighbors or my friends' parents seemed to like me.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

7. When I was a child, teachers, coaches, youth leaders, or ministers were there to help me,

Definitely True Probably True Not Sure Probably Not True Definitely Not True

8. Someone in my family cared about how I was doing in school.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

9. My family, neighbors and friends talked often about making our lives better.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

10. We had rules in our house and were expected to keep them.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

11. When I felt really bad, I could almost always find someone I trusted to talk to.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

12. As a youth, people noticed that I was capable and could get things done.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

13. I was independent and a go-getter.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

14. I believed that life is what you make it.

Definitely True Probably True Not Sure Probably Not True Definitely Not True

How many of the 14 circled "Definitely True" or "Probably True"? _____

Of these circled, how many of these are still true for me? _____

Patient Depression Questionnaire (PHQ-9)

	Not at all	Several Days	Majority of days	Nearly every day
1. Little interest or pleasure in doing things	0	1	**2**	**3**
2. Feeling down, depressed or hopeless	0	1	**2**	**3**
3. Trouble falling or staying asleep or sleeping too much	0	1	**2**	**3**
4. Feeling tired or having little energy	0	1	**2**	**3**
5. Poor appetite or over eating	0	1	**2**	**3**
6. Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	**2**	**3**
7. Trouble concentrating on things, such as reading a book or watching TV	0	1	**2**	**3**
8. Moving or speaking so slowly that other people notice. Or the opposite, being so fidgety or restless that you have been moving around more than usual	0	1	**2**	**3**
9. Thoughts that you would be better off dead or of hurting yourself	0	**1**	**2**	**3**
COLUMN TOTALS				
SUM TOTAL OF RED NUMBERS				

If you checked off ANY problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with others?

_____ Not difficult at all _____Somewhat difficult _____Very difficult _____Extremely difficult

STAFF USE ONLY PHQ-9 (Circle One)	
Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderate severe depression
20-27	Severe depression

Legal History

Current Charge(s): _____ Action Needed: _____

If currently incarcerated, do you have a projected release date from jail/prison? _____Yes _____No Date: _____

Criminal History		
Date	Charge	Resolution

Probation/Parole/Case Manager: _____ Agency: _____

Phone: _____ Address: _____

Have you ever prostituted? _____ Yes _____No If yes, when? _____

Did you work for someone else while prostituting? _____ Yes _____No

If yes, what was the name of that person? _____

Education/Employment History and Income

Last grade completed: _____ Degree: _____ Do you have a trade/skill? _____

Are you able to work? _____ If no, why? _____

Work Experience: Most Recent First				
From	**To**	**Company**	**Position**	**Why did you leave?**

Military Service

Have you ever served in the military? _____Yes _____No If yes, when/what capacity? _____

Discharge status: _____ Is an immediate family member in the military? _____

By completing and signing this application, I wish to be considered for admission to Hope Center Indy. All information provided is true to the best of my knowledge. I understand this is a Christ-centered, 15-month program for sexually exploited women. I authorize Hope Center Indy Staff to contact any references listed by me on this application.

_____

Applicant Signature Date

_____

Staff Signature Date