Resident Application

CHECK IN DATE

General Information

NEW	FIRST NAME	MIDDLE	LAST	RACE/ETHNICITY
				☐ Black or African American ☐ White ☐ Hispanic/Latino ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific ☐ Asian ☐ Other _____

SOCIAL SECURITY NUMBER	DOB	PHONE NUMBER	
ID TYPE (EX. NCDL)	ID STATE	ID #	ID EXPIRES
VETERAN? (Ex. Y/N)	MILITARY BRANCH	DATES/CONFLICTS	
STREET ADDRESS		APARTMENT	
CITY		STATE	ZIP
MARITAL STATUS		SPOUSE'S NAME	
RELIGION/DENOMINATION			DO YOU SMOKE?
NEXT OF KIN (NAME & RELATIONSHIP)		BIRTHPLACE (CITY, STATE)	

Emergency Contact

NAME	RELATIONSHIP	PHONE
STREET ADDRESS		APARTMENT
CITY	STATE	ZIP

Addictions

Please indicate below any drugs used, length of use, and last date of use.

	Length	Last Used		Length	Last Used		Length	Last Used
☐ ALC			☐ MOR			☐ MET		
☐ COC			☐ BAR					
☐ MAR			☐ AMP					

Health Conditions

☐ Diabetes
☐ Epilepsy
☐ Heart Disease
☐ TB (Tuberculosis)
☐ Hepatitis A B C
☐ High Blood Pressure
☐ HIV
☐ Seizures
☐ Mental Health (please specify) _____
☐ Other (please specify) _____

Medications _____

Drug Allergies _____

☐ Health Insurance Company _____

Education/Work History

EDUCATION (Highest Level Completed)	Do You Have Your GED / H.S. DIPLOMA? ☐ Yes ☐ No
WORK SKILLS	

Criminal History

DOC NUMBER	STATE(S) WHERE OFFENSE(S) OCCURRED	
PROBATION OFFICER		PHONE

Incarceration/Treatment History

WERE YOU DISCHARGED FROM ANY OF THE FOLLOWING FACILITIES IN THE LAST 30 DAYS? (CHECK ALL THAT APPLY)

- ☐ Criminal Justice System (Jails, Prisons)
- ☐ Behavioral Health System (Mental Health Hospitals, Substance Abuse Treatment)
- ☐ Healthcare System (Hospitals)

Government Compensation

Food Stamps $_____

Disability $_____

Social Security $_____

Other $_____

My signature indicates that I am enrolling into your 90 day program of my own free will. I agree to cooperate in the work program and abide by all the rules and regulations. I assume all the risks that might be incidental to my stay. I do hereby for heirs, executors, my administrators, myself or my representatives release and relinquish forever any and all claims of any nature whatsoever that may arise out of or in connection with my stay at the Winston-Salem Rescue Mission. I also give the Winston-Salem Rescue Mission permission to release information and/or records as the occasion arises.

I have read or have had read to me this application, and I accept the conditions as set forth by the Winston-Salem Rescue Mission. I also verify that the information provided on this application is true and accurate to the best of my knowledge. I understand that the falsification of this application or failure to observe the rules will result in an immediate dismissal from the program. If asked to leave, I will do so peacefully.

Signature _____ Date _____

WSRM Staff Signature _____ Date _____

Comments _____

Bed/Work Assignment

BED ASSIGNMENT	WORK ASSIGNMENT

PLEASE SEND ORIGINAL TO ADMINISTRATIVE OFFICES.

Office Use Only

RECEIVED	ENTERED	RESIDENT ID

Behavior Standards for Our Homeless Citizens

As a consumer of services in the community, we wanted to share with you these behavior standards:

1. **Respect your neighbor.** Don't trespass, litter, vandalize, or use without permission another person's property. You are subject to legal action if you break the law!

2. **Respect yourself.** Find private locations to conduct your personal affairs, including your bodily functions. Avoid criminal activity or the appearance of participating in criminal activity.

3. **Respect services.** Make full use of the shelter and services that the community has provided. Do your part to maintain the order and cleanliness of these services.

4. **Respect the community.** Be involved in positive, productive activities. Avoid panhandling, hanging out, or other behavior which "gives a bad rap" to our homeless citizens in the eyes of the rest of the community and visitors to our community.

5. **Respect your potential.** Seize the opportunity to gain housing, jobs, and services you need to become self-sufficient and a contributing member of the community.

Providers of shelter and services will support efforts to make sure that agency and client activities are consistent with these behavior standards.

Signed: Attested:

_____ _____

Agency: _____

Date: _____ Date: _____

Winston-Salem/Forsyth County Council on Services for the Homeless
4/18/06

Chronic Homelessness Assessment

Chronically homeless person – HUD defines a chronically homeless person as "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years." To be considered chronically homeless a person must have been on the streets or in an emergency shelter (i.e.not transitional housing) during these stays.

To perform an assessment for chronic homelessness, answer the questions below.

Assessment Date:

Unaccompanied Individual: ☑

Homeless Status-Indicate the frequency of the client's homelessness.

Continuously homeless for a year or more: ☐

4 episodes of homelessness in the past 3 years: ☐

Disabling Condition-Indicate if the client has a disabling condition.

Substance use disorder: ☐

Serious mental illness: ☐

Developmental disability: ☐

Chronic physical illness or disability: ☐

Is Chronically Homeless:

Winston-Salem Rescue Mission

Client Acknowledgment Form

I, _____, acknowledge that I have been informed of program practices and policies, and procedures as listed below:

1. Program objectives, guidelines, and expectations.
2. Winston-Salem Rescue Mission may use my picture, name and/or video-audio recordings for promotional reasons.
3. Confidentiality of personal information (Initial the option of your choice.)
    a. _____ I grant permission for personal information received at the WSRM to be shared with other individuals, such as:

    _____

    _____

    _____

    b. _____ I do not want any information about myself disclosed to anyone other than the ministry team of the WSRM.

4. _____ Consent to Videotape/Audiotape: To help ensure the high quality of services provided by the program, therapy sessions may be audiotaped or videotaped for training purposes. The client and, if applicable, the client's family consent to observation, audiotaping, and videotaping. Audio/video recording will be used for training and supervision purposes only and will remain confidential among the staff of the Winston Salem Rescue Mission. The contents of the audio/video recording will be destroyed upon completion of use.

Resident's Signature: _____ Date: _____

Winston-Salem Rescue Mission

Medication Contract

I understand that while at Winston Salem Rescue Mission I will take all of my medications as prescribed. If there are any changes to my medications I will notify Winston Salem Rescue Mission Staff immediately. I understand it will be my responsibility to provide Winston Salem Rescue Mission Staff with documentation of those changes signed by the prescribing medical professionals. Failure to take my medications as prescribed may result in termination from the program.

SIGN_____

DATE_____

STAFF_____

This agreement will be signed upon arriving at the Rescue Mission for check-in.

Winston Salem Rescue Mission
Authorization for Release of Information

Name:	DOB:	SS#:

The following agency(ies) have my permission to exchange/give/receive/share/re-disclose information and records regarding service delivery planning for the purpose of securing, coordinating and/or providing services for the above named persons. This information is subject to re-disclosure by the recipient. (Please identify all agencies that apply)

☒	Hospital	☒	Substance Abuse Agency	☒	Housing Authority Winston Salem
☐	School District	☐	Job & Family Services	☒	Financial Institution (Bank)
☐	Family Physician	☒	Health Clinic/Department	☐	Sheriff's Office
☒	Mental Health Agency	☒	Social Security Administration	☒	Police Department
☐	Employer	☐	Emergency Contact	☐	Legal Aid
☐	Emergency Contact Phone	☐	Veterans Services	☐	Other:

_____

(Please Print) Agency Name to provide Winston Salem Rescue Mission

_____

(Print Name) of the Winston Salem Rescue Mission Representative

The following information: _____

(All DATES)

The original copy of this form is on file at: **Mission Records Department (718 North Trade St. Winston- Salem NC 27101)**

I authorize sharing of the following information if needed by the receiving agency to secure, coordinate, and provide services to the individual: (Mark the box in the corresponding column to each type of information).

☒ Identifying Information (Name, birthdate, sex, race, address, telephone number)

☒	Social Security Number	☒	Case Information	☐	Vocational Assessments	☒	Home Study
☒	Individual Education Plan (IEP)	☐	Social History	☒	Grades & Attendance	☐	Transitional Plans
☒	Treatment/Service History	☐	Family Service Plan	☒	Smart / Phone File Evaluation	☒	Medical Information
☒	Psychological Evaluations	☒	Disability Information	☐	Other Medical Information	☐	STD's
☒	HIV and AIDS related diagnosis and treatment	☒	Substance abuse diagnosis and treatment	☐	Other:	☐	Other:

I understand that the Authorization for Release of Information shall remain in **effect for 1 year** past the date of my signature below unless otherwise stipulated. I also understand that I may cancel this Authorization for Release of Information at any time in writing with the date and my signature and delivering it to (Program/Case Manager) **and may result in my dismissal from the WSRM program.** The revocation does not include any information that has been shared between the time that I gave permission to share information and the time it has been canceled.

This authorization stating expires on the _____ day of _____, 20_____.

If applicable, date of revocation _____ day of _____, 20_____.

Participant Signature:	Date:

ANY INDIVIDUAL OR AGENCY RECEIVING THIS INFORMATION IS PROHIBITED FROM MAKING FURTHER DISCLOSURE OF THIS INFORMATION. IF THIS INFORMATION CONCERNS A PERSON ADMITTED FOR TREATMENT OF ALCOHOL OR DRUG ABUSE, THE CONFIDENTIALITY OF THIS INFORMATION IS PROTECTED BY FEDERAL LAW. FEDERAL LAW REGULATION (42 CFR PART 2) PROHIBITS YOU FORM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION EXCEPT WHEN THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION, IF HELD BY OTHER PARTY, IS NOT SPECIFIC FOR THIS PURPOSE.

For WSRM Program Purposes Use Only

Life Builders Protocol

The Rescue Mission is a faith-based program for men with addictions. The initial program is 90 days and men may be eligible for a (9) month program upon successfully completing the 90 day program.

The following are criteria for entrance into the Rescue Mission:

1. Cannot be a registered sex offender, other offenses may be considered.
2. We are a **NON-NARCOTIC facility**. This includes pain medications.
3. **MUST TEST NEGATIVE for DRUG and ALCOHOL TESTING UPON ENTRANCE.**
4. Must be capable of self-care—we are not handicap accessible—cannot be on dialysis
5. Cannot have more than two pieces of luggage when checking into the Mission.
6. **Cannot work for first 90 days OR attend school.**
7. Must be willing to participate in work therapy—legitimate disabilities can be accommodated.
8. Cannot leave Mission for ONE week upon checking in.
9. Must pay monthly program fees, if receiving income (30 % of total income).
10. Must have (30) days of medication, if the person is taking psych. meds. (**List of meds required**). **Any follow-up appointments with agencies or physicians must be arranged prior to checking in at the Mission.**
11. Personal vehicles are not allowed at the Rescue Mission.
12. **Person needs to have a Photo ID**
13. Person must be able to live in a shelter setting with other residents.
14. Does the person have special needs?
15. Does the person have legal issues? (**WE DO NOT PROVIDE TRANSPORTATION TO COURT).**
16. **Discharge Assessment** from the facility performing the discharge.
17. **NO CELLPHONES ALLOWED!**

If you need further information please contact us at (336) 723-1848.
Fax: (336) 725-8352