Resident Application

CHECK IN DATE

General Information

NEW	FIRST NAME	MIDDLE	LAST	RACE/ETHNICITY
SOCIAL SECURITY NUMBER	DOB	PHONE NUMBER		☐ Black or African American ☐ White
ID TYPE (EX. NCDL)	ID STATE	ID #	ID EXPIRES	☐ Hispanic/Latino ☐ American Indian or Alaska Native
VETERAN? (Ex. Y/N)	MILITARY BRANCH	DATES/CONFLICTS		☐ Native Hawaiian or Other Pacific ☐ Asian
STREET ADDRESS		APARTMENT		☐ Other ___
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:

____

Date: ______________________________

Attested:

____

Agency: ________________________

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______________________________________

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

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 homeless men and men with addictions. The Life Builders initial program is 90 days. Men may be eligible for a One Year Transformers program upon successfully completing the Life Builders Program.

The following are criteria for entrance into the Rescue Mission:

1. You must have a valid Photo ID. You cannot be a registered sex offender; other offenses may be considered.
2. **You must pass a DRUG and ALCOHOL screening upon entrance.** Cannabis must be out of your system by the 60th day of your entrance. We are a NON-NARCOTIC facility. This includes pain medications.
3. You must be able to live in a shelter setting with other residents. You must be capable of self-care. We are not handicap accessible—you cannot be on Dialysis. You must make known all medical conditions & special needs upon checking in.
4. You 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.
5. You cannot have more than two pieces of luggage when checking into the Mission. All luggage items will be searched before being checked in.

7. You may not work or attend school until you have completed the 90-day program.

8. You will be required to participate in work therapy, classes, and all required meetings. Legitimate disabilities can be accommodated.

9. You will be required to take part in a 30-day detox upon checking in. You cannot leave Mission property, have visitors, or make any phone calls without staff permission.

10. You will be required to pay monthly program fees, if receiving income (30 % of total income).

11. No personal vehicles are allowed at the Rescue Mission.

12. No Cellphones or mobile device are allowed until 90 days.

13. You must provide details of all current legal issues you are in involved in. **(WE DO NOT PROVIDE TRANSPORTATION OUTSIDE OF FORSYTH COUNTY).**

14. If you are coming from another facility, you must have a Discharge Assessment from the facility performing the discharge.

If you need further information please contact us at (336) 723-184
Email; programs@wsrescue.org Program Fax: 336-232-1687