Secure Fax - 336-232-1687

SCREEN DATE

Resident Application

SIZES: PANTS _____ SHIRT _____ BRIEFS _____ SHOES _____

General Information: Please Fill Application Out Entirely

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	ARE YOU A LEGAL USA CITIZEN: YES OR NO?
MARITAL STATUS	SPOUSE'S NAME		
RELIGION/DENOMINATION			DO YOU USE ANY TOBACCO PRODUCTS?
NEXT OF KIN (NAME & RELATIONSHIP)		BIRTHPLACE (CITY, STATE)	

Emergency Contact

NAME	RELATIONSHIP	PHONE
STREET ADDRESS		APARTMENT
CITY	STATE	ZIP

Medications

Please list all medications below:

Health Conditions

☐ Diabetes ☐ High Blood Pressure

☐ Epilepsy ☐ HIV

☐ Heart Disease ☐ Seizures

☐ TB (Tuberculosis) ☐ Mental Health

☐ Hepatitis A B C ☐ Other (please specify) _____

Have you been diagnosed with or treated by a doctor or healthcare facility for any mental health disorders. Please be specific.

_____

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

DO YOU HAVE ANY CURRENT CHARGES OR WARRANTS? YES/NO ☐	STATE(S)/COUNTY OFFENSE OCCURRED	DOC NUMBER
PROBATION OFFICER PHONE	ARE YOU A REGISTERED SEX OFFENDER?	ARE YOU ON HOUSE ARREST?

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 _____

Office Use Only

INTAKE DRUG SCREEN: PASS OR FAILED	IF FAILED WHAT SUBSTANCE:	RESIDENT ID/PASSCODE _____

Drug/Substance Abuse List

Please place an “X” on each drug that you have taken in the past.

USED ‘X”	Drug/Substance	Frequency	Method	First Use	Last Use
☐	Alcohol				
☐	Barbiturates (BAR)				
☐	Amphetamines (AMP)				
☐	Benzodiazepine (BZO, BEN, BENZ)				
☐	Buprenorphine (BUP)				
☐	Cocaine (COC)				
☐	Marijuana (THC)				
☐	Methadone (MTD)				
☐	Methamphetamine (METH, mAMP, MET)				
☐	Opiates/Morphine (OPI, MOR, MOP, OPI300, FTNL)				
☐	Oxycodone (OXY)				
☐	Phencyclidine (PCP)				
☐	Propoxphene (PPX)				
☐	Tricyclic Antidepressants (TCA)				

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. You cannot be on dialysis. You must make known all medical conditions & special needs upon checking in. Our building has limited accessibility and may not accommodate all physical disabilities.
4. **You must have (30 days) of medication**, if the person is taking psych. medication. (List of medications are required). Any follow-up appointments with agencies or physician 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.**
6. You may not work or attend school until you have completed the 90-day program.
7. **You will be required to participate in work therapy, classes, and all required meetings**. Legitimate disabilities are accommodated.
8. **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.
9. You will be required to pay monthly program fees, if receiving income (30 % of net income).
10. **No personal vehicles are allowed at the Rescue Mission.**
11. **No Cellphones or mobile device are allowed for 90 days**.
12. You must provide details of all current legal issues you are in involved in. (**We do not provide transportation outside of Forsyth County for legal or medical Appointments**).
13. If you are coming from another facility, you must have a Discharge Assessment from the facility performing the discharge.

If you need further information, you may contact our Intake Staff,
at (336) 723-1848, extension 100
Email: programs@wsrescue.org/Fax # (336) 232-1687

Winston Salem Rescue Mission
Authorization for Release of Information

Clients Full Name:	Date of Birth:	SSN:

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

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	☒	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 this "Authorization of Release of Information" shall remain in effect the entire time I am a resident at the Winston Salem Rescue Mission starting on the date of my signature below. I also understand that I may cancel this "Authorization for Release Information" at any time with assistance from a Program Staff Member. I understand this may affect the services I receive at the Winston Salem Rescue Mission and could result in dismissal from the program.

Participant Signature: Authorization Start Date: _____ day of _____, 20_____.

If Revocation Requested: _____ day of _____, 20_____. Participant Signature:

Reason for Revocation: Staff Signature:

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)