APPLICATION FOR RESIDENCE AT THE WOMEN'S CARE CENTER

To be accepted into the Women's Care Center an applicant must complete this application. Carefully read and honestly answer all the questions. Living at the Women's Care Center is a privilege, and if you understand its value, it will help you in the maintenance of your sobriety without relapse.

Women's Care Canter does not accept sex offenders or anyone convicted of a violent offense. We currently do not take anyone with an electric monitor. The Center is not a medical treatment facility. The facility does not accept anyone who has been prescribed mood-altering medications.

*** Please Print Clearly**

Date: _____ Social Security No.: _____

Name: _____ Date of Birth: _____

Present Address:_____

Is this a treatment facility? _____ Phone Number:_____

Are you an alcoholic? _____ Date of Last drink: _____

Are you addicted to drugs: _____ Date of Last use? _____

List of all drugs you have used:

_____

_____

Do you want to stop using drugs and drinking? _____

Are you willing to participate in the Spiritual program that we offer at Women's Care Center, including, but not limited to, daily devotions, Bible studies, church attendance, and 12-step meetings? _____

Are you currently in treatment or incarcerated? _____

If yes, where and how long?_____

Do you have any current pending charges? _____ If yes, explain:

_____

_____

List all criminal convictions including the City, County, and State for each conviction:

_____

_____

_____

_____

Are you a Registered sex offender? _____ What is your current monthly income?_____

What is your marital status? _____ Do you have children? _____

If yes, how many? _____ Do you owe child support? _____

Have you ever been to a treatment facility for drug or alcohol addiction?
_____

If yes, how many times? _____ When was the last time? _____

Where?_____

Do you have a medical doctor? _____List the names of all doctors you have seen in the last three years.
_____

_____

List all the pharmacies you have used in the last year: _____

_____

Present Medical History

Check those questions to which you answer yes (leave the others blank).

- ☐ Has a doctor ever said your blood pressure was too high?
- ☐ Do you ever have pain in your chest or heart?
- ☐ Are you often bothered by a thumping of the heart?
- ☐ Does your heart often race?
- ☐ Do you ever notice extra heartbeats or skipped beats?
- ☐ Are your ankles often badly swollen?
- ☐ Do cold hands or feet trouble you even in hot weather?
- ☐ Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack, or coronary?
- ☐ Do you suffer from frequent cramps in your legs?
- ☐ Do you often have difficulty breathing?
- ☐ Do you get out of breath long before anyone else?
- ☐ Do you sometimes get out of breath when sitting still or sleeping?
- ☐ Has a doctor ever told you your cholesterol level was high?
- ☐ Has a doctor ever told you that you have an abdominal aortic aneurysm?
- ☐ Has a doctor ever told you that you have critical aortic stenosis?
- ☐ Are you pregnant?
- ☐ Could you be pregnant?

Comments

_____

Do you now, have, or have you recently experienced:

- ☐ Chronic, recurrent or morning cough?
- ☐ Episodes of coughing up blood?
- ☐ Increased anxiety or depression?

- ☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
- ☐ Migraine or recurrent headaches?
- ☐ Swollen or painful knees or ankles?
- ☐ Swollen, stiff or painful joints?
- ☐ Pain in your legs after walking short distances?
- ☐ Foot problems?
- ☐ Back problems?
- ☐ Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhea?
- ☐ Significant vision or hearing problems?
  - ☐ Recent change to a wart or mole?
  - ☐ Glaucoma or increased pressure in the eyes?
  - ☐ Exposure to loud noises for long periods?
  - ☐ An infection such as pneumonia accompanied by a fever?
  - ☐ Significant unexplained weight loss?
  - ☐ A fever, which can cause dehydration and rapid heartbeat?
  - ☐ A deep vein thrombosis (blood clot)?
  - ☐ A hernia that is causing symptoms?
  - ☐ Foot or ankle sores that will not heal?
  - ☐ Persistent pain or problems walking after you have fallen?
  - ☐ Eye conditions such as bleeding in the retina or detached retina?
  - ☐ Cataracts or lens transplant?
  - ☐ Laser treatment or other eye surgery?

Comments_____

List any prescription medications you are now taking:

_____

_____

_____

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:

_____

_____

Date of last complete physical examination: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Cannot remember

Date of last pap smear and mammogram? _____

☐ Normal ☐ Abnormal ☐ Never ☐ Cannot Remember

Date of your last tetanus shot? _____

Date of last chest x-ray: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Cannot Remember

Date of last electrocardiogram (EKG or ECG): _____

☐ Normal ☐ Abnormal ☐ Never ☐ Cannot Remember

Date of last dental check-up: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Cannot Remember

List any other medical or diagnostic test you have had in the past two years:

_____

List hospitalization, including dates of and reasons for hospitalization:

_____

_____

List of any drug allergies

_____

_____

Past/Current Medical History

Check those questions to which your answer is yes (leave others blank).

- ☐ Heart attack if so, how many years ago? _____
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Diseases of the arteries
- ☐ Varicose veins
- ☐ Arthritis of legs or arms
- ☐ Diabetes or abnormal blood-sugar tests
- ☐ Phlebitis (inflammation of the veins)
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Diphtheria
- ☐ Scarlet Fever
- ☐ Infectious mononucleosis
- ☐ Nervous or emotional problems
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Current STD
- ☐ Hepatitis A, B, or C
- ☐ HIV +
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Abnormal chest X-ray
- ☐ Other lung disease

- □ Injuries to back, arms, legs, or joints
- □ Broken bones
- □ Jaundice or gall bladder problems
- □ Tuberculosis

Comments_____

_____

Do you have any mental illness or diagnoses? _____

Have you ever attempted suicide? _____

If yes, please explain mental health or suicide attempts:

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_____

_____

Do you take prescription or psychotropic drugs? _____

If yes, list all medications you take and the reason you take them:

_____

_____

_____

Date you would like to enter Women's Care Center: _____

Do you have a valid driver's license? _____Birth Certificate? _____

Do you have a Social Security Card? _____ Photo Id? _____

List 3 Emergency Contacts: **NAME** **NUMBER** **RELATIONSHIP**

1. _____
   _____
2. _____
   _____
3. _____
   _____

List of any special medical requirements you have or need:

_____

_____

_____

_____

Do you have any known allergies? _____ If yes, then list:

With my signature, I hereby declare that Main Street Ministries and Women's Care Center is not responsible for any injury, medical condition, or self-inflicted injury during my stay.

It is also my understanding that *drug test and breath analysis will be conducted on a random basis*, during house meetings and after returning from day and overnight passes or if the Women's Care Center Manager or staff deems it necessary due to erratic, suspicious or unusual behavior.

By signing this document, I am giving my consent to be tested by Women's Care Center staff, by way of urinalysis and breath analysis, for the use of drugs and alcohol.

I also understand that if any drug test administered to me turns out positive, I will be referred to the Executive Director, and will be immediately expelled from the Women's Care Center.

Secondary knowledge: I also understand that if I find out that one of my house mates is using drugs (other than those prescribed for her) or alcohol, and I don't say anything, and it is proven that I was aware of it, I too will be referred to the Executive Director, and could be expelled from Women's' Care Center.

I hereby declare that the information provided by me about my medical history and condition is accurate. I understand any untruthful statement or information is grounds for immediate dismissal from the program.

_____

Resident's Signature

Date_____

_____

Women's Care Center Manager

Date_____

I have read all the material on this form. I have answered each question honestly and want to achieve a comfortable recovery from alcoholism and/or drug addiction without relapse. _____

In Your Own Words

Please list why we should consider your Women's Care Center application.

Why do you think you are ready to change? List three to give goals you want to achieve in the next 6 months.

_____

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WOMEN'S CARE CENTER

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This document fulfills all state and federal regulations to the Texas Civil Rights Practice and Remedies Code (Section 74.052); the Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Part 160 and 164); and the federal and state laws pertain to and commonly referred to as "HIPPA," and any and all other acts cited below. **AUTHORIZATION FOR DISCLOSURE RELEASE INFORMATION/MEDICAL RECORDS**

Health Insurance Portability and Accountability Act of 1996
45 CFR Subtitle A, Subchapter C, Part 164.512 € (1) (iii)

NAME: _____ SOCIAL SECURITY NO: _____

DATE OF BIRTH: _____

Date of service/treatment to be received/released: _____to date of final disposition.

CLASS OF PERSONS AUTHORIZED TO MAKE THE DISCLOSURE:

All physicians and other health care providers who have examined, treated, consulted with, or x-rayed _____ (*applicant's full legal name*) and all hospitals, nursing facilities, rehabilitation facilities, clinic, or laboratories in which I have been and/or currently a patient and/or resident.

DESCRIPTION OF INFORMATION TO BE DISCLOSED:
You are hereby authorized and directed by the undersigned to give to the bearer of this authorization, or any photo static copy thereof, any and all information relative to the undersigned and named applicant's physical, emotional, and mental condition and permit the bearer to examine x-rays, laboratory reports, and medical records of any kind of which reflects diagnosis, treatment, prognosis, and any other information concerning illness, injuries, or disability. Such information shall specifically include, but is not limited to, itemized billing records/statements, history & physical, operative reports, lab/pathology reports, consultation reports, physicians' orders, discharge/death summary, x-ray reports/images, other radiographic reports/images, emergency room records, face sheets, nurses' notes, flow sheets, pharmacy and medication records, care plans, assessment tools, screening tools, summaries, social workers, legal, and monitor strips, readouts or printouts. I understand that the specified information to be received/released may include, but is not limited to: history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, psychological and/or psychiatric treatment, counseling records/note, genetic testing or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). You are hereby authorized and directed to make available all such information for inspection and copying.

DURATION OF THIS AUTHORIZATION:
This authorization expires one (1) year from the date signed.

RIGHT TO REVOKE:
I understand that I may revoke this authorization in writing at any time by contacting the Women's Care Center, except to the extent that action has been taken in reliance upon the authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected.

I understand that I have a right to a copy of this authorization.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances, such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

A photostatic copy of this authorization shall be considered as valid as the original.

This authorization applies to Women's Care Center, as the releaser/receiving institution and recipient of all records and information contained in this notice.

_____ _____

DATE SIGNED **PRINT NAMED PERSON LEGALLY AUTHORIZED TO MAKE RELEASE**

_____

SIGNATURE OF PERSON LEGALLY AUTHORIZED TO MAKE RELEASE