



A Ministry of Family Life Services of Emporia, Inc.

APPLICATION PACKET FOR RESIDENTS

www.shilohhomeofhope.org

P.O. Box 748
Emporia, KS 66801

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888-797-3002

fls.shiloh@hotmail.com

*Do not conform any longer to the pattern of this world,
But be transformed by the renewing of your mind.
Then you will be able to test and approve what God's will is-
His good, pleasing and perfect will. Romans 12:2*

Shiloh Home of Hope for Women

APPLICATION FOR Shiloh Home of Hope for Women

Name: _____ Date _____

Address: _____

City _____ State _____ Zip _____

Cell Phone # () _____ E-mail _____

Telephone # home () _____ Work # () _____

Telephone # () _____

Have you ever applied to Shiloh in the past? _____ If YES please give approximate date: _____

Information About You

Date of Birth: _____ Age: _____ Race: _____

City and State of Birthplace: _____

Social Security Number: _____

Driver's License Number (and expiration date): _____

Physical Characteristics:

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Marital Status

Single _____ Married _____ Divorced _____ Seperated _____

Children

Do you have any children? _____ How many? _____

List Names and ages:

1. _____ Age: _____

2. _____ Age: _____

3. _____ Age: _____

Will any of the children not be staying with you at Shiloh, if so, please indicate? _____

What other arrangements, if needed, are being made for your children while you are at Shiloh?

Who has custody of your children? _____

Please explain how much and what type of contact the children's birth father(s) has with your child(ren) _____

Are you on any type of government or financial assistance? _____

Will your coming to Shiloh have any affect on this assistance? _____

Educational

Name of last school attended: _____

Dates of Attendance: _____

Did you graduate? _____ If not, last grade completed? _____

Have you ever been in any special education classes? _____ If so, please list: _____

Do you plan on obtaining a GED while at Shiloh (yes or no)? _____

Pregnancy

Are you pregnant? _____ Approximate Due Date: _____

Has a doctor confirmed your pregnancy? _____

Is the birth father aware of your pregnancy? _____

What involvement do you anticipate the birth father having with you and your baby during and after your pregnancy? _____

Are you considering parenting _____ placing _____ undecided _____ your child? *(Please indicate choice)*

Shiloh Home of Hope firmly believes in allowing you to make the choice between adoption and parenting. We believe that while you are here God will give you direction for your life and that of your unborn child.

Medical

Do you have any allergies? _____ List: _____

List any and all medications that you take:

Medication	Dosage	Reason	For How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you on a special diet? _____ Explain: _____

If yes, was this diet prescribed by a Doctor? _____ Dr's name and phone #: _____

Do you eat meat? _____

Do you have, or have you ever had, a problem with food or eating? _____ Explain: _____

Have you been diagnosed with an eating disorder, or treated by a physician? _____

Dr's name and phone #: _____

List any physical limitations that you may have as indicated by a physician: _____

Reason: _____

List all past surgeries, or medical hospitalizations (include dates): _____

Financial

Do you have any outstanding debts? _____ Explain _____

What arrangements will you make for their payment while you are at Shiloh? _____

Would the finances for your personal needs while at Shiloh Home of Hope be sponsored by a church, ministry, family or individual? _____ If so, whom? _____

Shiloh Home of Hope provides food and shelter, but we are not responsible for medical expenses. It is the responsibility of our residents to cover these expenses. Arrangements should be made prior to residency. If none is available to you please inform Shiloh staff during your interview.

Legal Background

Have you ever been arrested? _____ How many times? _____ Dates, charges: _____

Do you have pending court dates? _____ Explain: _____

Are you currently incarcerated? _____ How long? _____ Length of Time Remaining: _____

Name of Attorney or Legal Representative: _____

Telephone #: _____

Have you ever been on probation or parole? _____ Are you now? _____

How long? _____ Length of Time Remaining: _____

How often do/should you report? _____ In person or through mail? _____

Name of probation or parole officer: _____

Address: _____

Telephone #:() _____

Have you or a child in your care been in situations that resulted in another adult being charged with and/or convicted of a crime? _____ If so, dates, charges, names, city, county, state and outcome:

Substance Abuse

Have you ever experimented with the following substances? (Circle)

- | | | |
|---|---------------------------------|----------|
| Alcohol | Hallucinogenic (Acid,LSD,etc..) | Morphine |
| Amphetamines (uppers) | Crank | Opium |
| Barbiturates (downers) | Crystal Meth | Heroin |
| Cocaine | Marijuana | Ecstasy |
| Crack | Meth Amphetamines | Tobacco |
| Inhalants (Glue, Paint Thinners, etc..) | Other: _____ | |

Drug of Choice:

- 1) _____ Length of Use _____
- 2) _____ Length of Use _____
- 3) _____ Length of Use _____
- 4) _____ Length of Use _____

Habit cost per day? _____ Longest Period Clean? _____

*Have you ever been in an alcohol, drug, or detoxification program before? _____ (Please list facilities below)

Was it religious or non-religious? _____

<u>Date of entry</u>	<u>Program Name</u>	<u>City/State</u>	<u>Reason for Leaving</u>	<u>Date of Discharge</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Counseling

Have you ever been diagnosed or treated for (please mark yes or no): DID/Dissociative Disorder ___ ADD ___ ADHD ___ Schizophrenia ___ Bi-Polar ___ Borderline Personality Disorder ___ ?

*Have you ever been to counseling? _____ (Please list facilities/persons below)

*Have you ever received psychiatric care or been in a psychiatric hospital? _____ (Please list facilities....)

Counseling and/or Psychiatric Care:

<u>*Date of entry</u>	<u>Program Name</u>	<u>City/State</u>	<u>Reason for Leaving</u>	<u>Date of Discharge</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please sign forms with the above *facilities/programs/counselors and have your records forwarded to Shiloh Home of Hope.

Have you ever been a victim of rape_____ or incest_____? How old were you?_____

Have you ever been a victim of sexual abuse_____ physical abuse_____ or ritual abuse_____?

Have you ever been involved in prostitution? Yes_____ No_____ Lesbianism? Yes_____ No_____

Have you ever tried to commit suicide?_____ When?_____

Why?_____

Have you ever self-mutilated? Yes_____ No_____ How?_____

Family

Do you and your parents get along?_____

Do you live with them? Yes_____ No_____

Are they Christians?_____ For How Long?_____

Denomination and name of church:_____

Spiritual

Have you ever witnessed or been involved in the following occult activities? (Circle)

- | | | |
|----------------------|--|-----------------------|
| Astroprojection | Satanic Worship | Rituals |
| Divination | Séances | Sacrifices |
| Fortune Telling | Spell Casting | Spiritism |
| Horoscopes | Tarot Cards | Psychic Consultations |
| Levitation | Voodoo | Chanting |
| Ouiji Boards | Witchcraft | Channeling |
| Palm Reading | White Magic | |
| Witches Coven | Putting Curses on Others | |
| Dungeons and Dragons | Programming (color, number, locations, etc.) | |

Write a brief explanation of you involvement with each occult activity: _____

Have you ever been abused in any of these activities?

Explain: _____

Have you ever been involved in any of the following groups? (Circle)

Christian Science

Mormonism

Eastern Religions

Scientology

Jehovah's Witnesses

Transcendental Meditation

Brotherhood

New Age Movement

Write a brief explanation of your involvement with each: _____

Have you ever committed your life to God? _____

Date: _____ Place: _____

Denominational background: _____

Are you a member of any church or religion? _____

Which one? _____

How often do you attend church? _____

Do you read the Bible? _____ How often? _____

Do you ever pray? _____ How often? _____

Do you feel that you have a need for God? _____ Explain: _____

What is your present relationship with God? _____

Have you ever considered rededicating your life to God? _____

Are you willing to do it now, if necessary? _____

Why would you like to come to Shiloh? _____

What would you like to see happen in your life while at this home? _____

I have read the rules of this program and agree to submit to the rules and the staff of Shiloh Home of Hope for *Women*. I understand that if I have failed to answer these questions truthfully or withheld any information, it can be considered grounds for refusal to or dismissal from the program.

Signature: _____

Date: _____

Your First 30 Days

The first 30 days of resident's stay in our program is filled with many challenges. This most often includes homesickness, struggles with trust, environmental changes, and a roller coaster of emotions. The first inclination of the resident is the desire to leave prematurely, before the adjustment period is complete. Most of this passes after the first 30 days.

We are requiring a strong commitment on your part to enter this program with a determination in your heart to see it through to the end. Your signature to this 30 day commitment form is your agreement to not compromise your decision to change, and, therefore, agree to give no time or expression to such ideas as, "I'm too homesick," "This is too hard," and/or "I'm not ready for this." We understand that feelings of being homesick and missing your family are valid. However, you must determine now that you will not allow these feelings to drive you from your commitment to what God has for you through Shiloh Home of Hope.

The first 30 days is the first step of many in the healing process. Your signature represents your commitment and desire to do what it takes to achieve freedom and healing. We are committed to you as long as you are committed to us.

I, _____, understand that the first 30 days at Shiloh is a critical transition period and requires my dedication to fulfill my determination to change. By my signature, I choose to not allow myself to compromise this decision.

If you do not agree to this commitment, please do not proceed with the application process.

If you do agree, please proceed to the following page.

Signature of Applicant

Date

Understanding the 6 Month Commitment

The first 30 days are crucial to the beginning of the program. Your commitment to this initial time will set in motion what you need to complete the program. Once the first 30 days of transition have passed, the next several steps in the healing process will require an average of 6 to 18 months and a strong understanding of your initial commitment. We look at this commitment as if it were a legally binding document signed by you giving us your word that you will not change your mind about staying with us at Shiloh for an average of six months.

It is not acceptable to sign this agreement and then say, "I don't care, I want to go home." We believe God makes a divine appointment for every young woman who comes to Shiloh. This is a place where young women can come who are serious about changing their lifestyle and/or receiving healing for life issues that have damaged them emotionally, spiritually, and physically. We take our commitment to minister to you seriously, and we expect your commitment to be as serious to us that you will focus on working through your issues and allowing the Lord to minister to you while you are here.

Each situation is different. There is no guarantee that your healing process will be complete in 6 to 9 months. The staff at Shiloh are committed to do whatever it takes to complete what God wants to do in your life.

If you feel you cannot give us your solemn word that you will fulfill this commitment of six months, do not sign this agreement. Your life is worth the time, please take it.

God bless you in your decision about the future.

Sincerely,

Carol Alderman
House Manager
Shiloh Home of Hope for Women

6 Month Commitment Agreement

I, _____, agree to commit to stay at Shiloh Home of Hope for a minimum of 6 months. I understand that this is the minimum amount of time generally needed to work through issues.

Please read over everything and sign the six month commitment agreement. This will help you to stick with the program while you are adjusting to your new environment. The staff at Shiloh looks forward to meeting you and working with you.

Sincerely,

Carol Alderman
House Manager
Shiloh Home of Hope for Women

Signature of Applicant

Date

HOUSE RULES

Activities:

Everyone participates in all activities unless given special permission to be excused by staff member in charge.

Residents stay together as a group under supervision of a staff member during activities.

Check-In:

When residents arrive, all of their belongings will be checked in by a staff member.

Church:

Weekly church attendance is required.

Effort will be made to allow residents to attend the denomination (mainstream Christian denominations) of their choice. This depends on the availability of people from the different churches to take on the responsibility of transportation and other arrangements necessary.

Discipline

Discipline will be given for disobedience and wrong attitudes. Extra household duties, restriction from privileges, essays, and even dismissal will be used.

Dismissal:

You may be subject to dismissal from the program for the following behavior:

- using drugs, alcohol, or cigarettes or for having them in your possession
- leaving the property without permission
- being continually uncooperative
- **not showing a sincere desire for help**

Girls must be willing to change and have a sincere desire for help.

Dress Code:

Clothing must be clean and modest at all times.

Bathing suits must be modest.

Some type of clothing (in addition to underclothing) must be worn at all times, including to and from the bathroom.

Neatness and cleanliness are expected.

Girls are to shower every day.

Household Duties:

Girls are assigned and responsible for household duties that are supervised by the staff in charge. The same person who does a job incorrectly must correct it.

When a special need arises, every girl's cooperation in doing extra duties will be required.

Mail:

Questionable mail will be opened and read by staff.

Inappropriate correspondence will be denied. Residents will be informed if they receive mail that was deemed inappropriate.

Residents may be asked not to correspond with individuals who have proven to be a negative influence, or are connected to past problems.

Marriage Relationships:

In isolated cases, a married girl will be allowed to enter the program. We will allow the Spirit of God to direct us in each situation, according to what is needed.

Relationships:

Girls are not allowed to develop romances or date during the first two stages of the program. Stage 3 residents are allowed to date.

Relationships with childrens' fathers and husbands of residents will be evaluated on a case-by-case basis.

Smoking:

Smoking is never permitted at Shiloh.

Telephone Calls:

Stage 1 residents have supervised phone times on Sunday afternoons or evenings.

Staff members will monitor the calls. Residents may not be allowed to talk to individuals who have proven to be a negative influence, or are connected to past problems.

Lay Counseling

Client will have private, individual lay counseling sessions scheduled once a week. Clients are to notify the staff on duty if they need immediate help or counsel.

Visitation:

All visitors and visits must be approved and arranged with the house manager one week ahead of time. Generally, visits will be scheduled on Sunday afternoons. Visits will take place in designated areas of the home and will be monitored.

Residents may be allowed to leave for visits outside the home after they have been at Shiloh for two months. These visits will be evaluated on a case by case basis, with the determining factors being the readiness of the resident to be away from Shiloh and the influence the people she is visiting on her. These visits will need to be approved by the House Manager or Director of Services. These visits might be for a Sunday afternoon or a weekend. It is important that the people the resident is visiting are positive influences on her and will help her to make good choices while away from Shiloh. The people the resident is leaving with are responsible for picking her (and her children) up and returning them at whatever time is agreed to. These types of visits are limited to one per month at the most.

Shiloh Home of Hope for *Women*

You will be furnished with the following items to use:

blankets	bath towels	Bible
pillows	wash clothes	plastic basket for toiletries
sheets	laundry basket	alarm clock

Items to bring:

Clothes:

Bring clothes and coats for yourself and your children. Please remember that we have limited space. Your belongings must fit in your room.

Prescription Medications:

If you or your children are on any prescription strength medications please bring a 30 day supply with you upon entry into the program. This does not apply for prescriptions which are short term or temporary such as antibiotics, but rather those taken on a continual basis. Common over the counter medications will be provided and available for you on an as needed basis.

Additional items you may want to bring:

- Personal items such as shampoo, deodorant, feminine hygiene items, make-up, etc. We have many of these things on hand, but if you want to make sure you have a particular type/brand you will want to bring your own.
- Notebook, journal, pens and pencils

Optional Items:

- Christian music. Only Christian music is allowed during stage 1. This does not mean we believe that all mainstream music is wrong. We are simply attempting to create a spiritual atmosphere that is conducive with your purpose for coming to Shiloh.
- Christian books. Only Christian books are allowed.
- Children's items: we have ample supply of baby items and toys for young children, please limit what you bring to things that are important to your children, space is limited.
- Cell phones – you are permitted to bring a cell phone but you will only be allowed to use it on Sundays in accordance with normal telephone rules (see above). If having a cell phone becomes a problem it will be disallowed.

Keep in mind that we have limited space, so please plan accordingly. Everything you bring must fit in your room in an orderly fashion. You are not allowed to bring furniture. **If you are unsure about bringing an item, please call with questions.**

Medical Form Shiloh Home of Hope

Name _____

General Exam

General Appearance:

Height _____ Weight _____

Vital Signs:

Blood Pressure _____ Temp. _____

Pulse _____ Resp. _____

Vision: Without Glasses R-20 _____ L-20 _____

With Glasses R-20 _____ L-20 _____

	Normal	Abnormal (Explain)
Eyes		
Ears		
Nose		
Throat		
Teeth		
Cardiovascular		
Neurological		
Extremities		

Any sign of contagious disease?

Physician's signature: _____

Date: _____

Shiloh Home of Hope

Name _____

IMMUNIZATION RECORD

Please provide a copy of your immunization card, if possible.

(Enter Dates)

	NONE	1	2	3	4	UNKNOWN
1. Inactivated Polio						
2. Diphtheria, Pertussis, Tetanus						
3. MMR or separate immuns. of : Red Measles, Rubella, Mumps						
4. Tetanus						

The following additional immunizations are required of applicants between the ages of 13 and 16:

	NONE	1	2	3	4	UNKNOWN
1. Hepatitis B						
2. MMR or separate immuns. of: Red Measles, Rubella, Mumps: Second dose						
3. Tetanus (if applicable)						

Shiloh Home of Hope

Name: _____

REQUIRED LAB WORK

1. Tuberculin Test

a. Date Test Given: _____ b. Date checked: _____

Results of Test _____

2. STD Testing: **All testing is required. We also require copies of lab work.**

Results:

Syphilis _____

Gonorrhea _____

Chlamydia _____

Hepatitis C _____

HIV _____

3. Other Testing:

Blood type: _____

Hgb/Hct: _____

Pap Results: _____

Physician's signature: _____

Date: _____

Shiloh Home of Hope

Name: _____

Please complete the following form **ONLY IF YOU ARE PREGNANT**

Gynecological exam: Date of LMP _____

Results of Pelvic Exam: Cervix _____

Uterus _____

Vagina _____

Breast: Shape and appearance of breast and nipples

Pregnancy: Date of LMP _____ Weight _____

Due Date _____

Cervix _____

Ultrasound results (if done) _____

Physician's impressions, comments and diagnosis of girl's health: _____

Problem List/Plan

Physician's Signature

Date

Physician's telephone number _____

Address _____

CONDITION	YES	NO
Rheumatic fever		
Heart trouble		
Asthma		
Blood in urine		
Burning on urination		
Frequent kidney infections		
Kidney stones		
Vomiting blood		
Diarrhea		
Constipation		
Arthritis		
Blackout spells		
Convulsions		
Backache		
Fatigue		
Dizziness		
Excessive fatigue		
Are you nervous?		
Are you depressed often?		
Do you worry?		
Do you sleep well?		
Are you excessively sleepy?		
Do you cry easily?		

Condition	Yes	No	Age	Condition	Yes	No	Age
Scarlet Fever				Syphilis			
Measles				Gonorrhea			
Chickenpox				Diphtheria			
Mumps				Hepatitis			
Whooping Cough				Tuberculosis			
Smallpox				Pneumonia			
Typhoid Fever				Nervous Breakdown			
Cancer				Goiter			
Anemia				TB			

List Allergies _____

List drugs to which you are allergic or sensitive to _____

Any other past or present illness (es) not listed _____

Do you have epilepsy? Yes _____ No _____ Type _____

Have you had a blood transfusion? Yes _____ No _____ When _____

List medications you take (bring medicine with you) _____

List all surgery you have had with dates _____

Do you have special diet requirements? Yes _____ No _____ Explain: _____

Your age at the time of your first period _____ Days between periods _____

Length of period _____ Flow: Heavy _____ Avg. _____ Light _____

Any bleeding between periods? _____ Number of pregnancies? _____

Number of full-term _____ Number of Miscarriages _____

Weight of largest baby: _____ Any complications with any pregnancy? _____

Shiloh Home of Hope for *Women*

FAMILY HISTORY (Whether living or deceased)

Relative/Name	Age	Condition of Health	Age at Death	Cause of Death
Mother:				
Father:				
Sisters:				
Brothers:				
Children:				

Medical Insurance Information Form

Section A

1. Name, address and telephone number of family practitioner:

2. Do you have current individual insurance coverage? Y/N:

Dental _____ Vision _____ Medical _____

3. If you are a dependent, are you covered by your parent/legal guardian's policy? Y/N: _____

Please call your insurance provider for assistance in answering the following questions. If you do not have insurance, please proceed to Section B of this form.

4. Name of insurance provider: _____ Policy number: _____

Group number: _____

5. Does your policy provide medical coverage outside of your network for both emergency and non-emergency visits? Y/N _____ What % does it cover? _____

If not, please specify: _____

6. What is your Dr. visit co-pay inside of the network? _____

What is your Dr. visit co-pay outside of the network? _____

1. *Do you have prescription drug coverage? Y/N: _____

*If yes to above, are prescriptions covered outside of the policy network? Y/N _____ What %? _____

*If you do not have prescription drug coverage, Shiloh Home of Hope will require a \$100.00 deposit to cover any prescription costs that are accrued during your/your daughter's time in the program.

2. Will your insurance policy cover all of the following possible medical needs while at Shiloh? Please check those that are covered:

*Normal Pregnancy _____ *Complicated Pregnancy _____

Emergency Room _____ Hospitalization _____

Lab Work _____

If your policy does not cover each of the four above-mentioned needs, then Shiloh will require an additional medical deposit of \$100.00. *Please note that coverage for these needs is only required for applicants who are pregnant.

Shiloh will require your insurance, prescription and social security cards upon arrival into the program (No copies please).

SHILOH HOME OF HOPE

RELEASE OF INFORMATION FORM

All matters relating to applicant and information are considered confidential and are treated as such by the staff of Shiloh. Information regarding such matters cannot be given without the written consent of the applicant or parent/guardian.

Name of Applicant: _____

Date: _____

I, _____, do hereby give permission for Shiloh Home of Hope to share information related to my application to the program with:

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

I also give the following person (s) and/or facility (ies) permission to exchange the following information with Shiloh Home of Hope for the purpose of application to the program.

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

- _____ medical records and information
- _____ personal history information
- _____ educational information and records
- _____ psychological records, psychiatric records, discharge summaries, treatment records and summaries, counseling records

This release will expire on (date) _____ unless written notification by the applicant or parent/guardian (if applicable) indicates otherwise.

Signature of Applicant

Date

Signature of Parent/Guardian (if applicable)
and relationship to applicant

Date

Signature of Witness

Date

Background Check Information Form

RELEASE OF INFORMATION

I, _____, give my permission for the release of any information concerning myself.

I understand that all information released will be for the exclusive and confidential use of Shiloh Home of Hope for *Women*.

PLEASE COMPLETE THE INFORMATION BELOW BY PRINTING IN INK.

Print First Name _____ **Print** Middle Name _____

Print Last Name _____

Print Maiden and Married Names, Nick Names or other Names used:

Date of Birth _____ **Race** _____

Social Security # _____ **Gender** ___ Male ___ Female

Current Address

Phone _____ **Cell** _____

Email _____

Signature _____

Date _____

Please contact Carol Alderman, if you have any questions about this form or the results from the background check. All information remains confidential.