



# ALPHA ACRES Recovery Program Application

CHECK IN DATE



## General Information

FIRST NAME		MIDDLE		LAST		RACE/ETHNICITY <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific <input type="checkbox"/> Asian <input type="checkbox"/> Other _____
SOCIAL SECURITY NUMBER		DOB				
ID TYPE (EX. NCDL)		ID STATE	ID #		ID EXPIRES	
PHONE NUMBER						
STREET ADDRESS			APARTMENT			
CITY				STATE		ZIP

We must have (3) different telephone numbers that we can call when we have an available date for you to check in, or in case of emergency.

(1) PHONE NUMBER	NAME	RELATIONSHIP
(2) PHONE NUMBER	NAME	RELATIONSHIP
(3) PHONE NUMBER	NAME	RELATIONSHIP

MARITAL STATUS		SPOUSE'S NAME		# OF CHILDREN
VETERAN? (Ex. Y/N)	MILITARY BRANCH		DATES/CONFLICTS	

## Emergency Contact

NAME		RELATIONSHIP		PHONE
STREET ADDRESS			APARTMENT	
CITY		STATE	ZIP	

## Education/Work History

EDUCATION (Highest Level Completed)		GED acquired? <input type="checkbox"/> Yes <input type="checkbox"/> No
SPECIAL SKILLS		

## Addictions

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

<input type="checkbox"/> ALC	Length _____	Last Used _____	<input type="checkbox"/> MOR	Length _____	Last Used _____	<input type="checkbox"/> MET	Length _____	Last Used _____
<input type="checkbox"/> COC	Length _____	Last Used _____	<input type="checkbox"/> BAR	Length _____	Last Used _____		Length _____	Last Used _____
<input type="checkbox"/> MAR	Length _____	Last Used _____	<input type="checkbox"/> AMP	Length _____	Last Used _____		Length _____	Last Used _____

## Health Conditions

<input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart Disease <input type="checkbox"/> TB (Tuberculosis) <input type="checkbox"/> Hepatitis    A   B   C	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV <input type="checkbox"/> Seizures <input type="checkbox"/> Mental Health (please specify) _____ <input type="checkbox"/> Other (please specify) _____
DO YOU HAVE ANY ALLERGIES? (PLEASE SPECIFY)	
HAVE YOU EVER HAD CONVULSIONS, SEIZURES, OR BLACKOUTS?	
PLEASE RATE YOUR HEALTH IN THE FOLLOWING AREAS:	
	Excellent      Good      Fair      Poor
Physical	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Mental	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Emotional	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Spiritual	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

## Medications

MEDICATION	DOSAGE	FREQUENCY OF USE	REASON FOR USE

(Please attach an extra sheet for any additional medications)

## Insurance

**PLEASE NOTE:** We are not a medical facility and cannot give medical care. We need to know who will be responsible for medical expenses incurred while you are here.

INSURANCE COMPANY	POLICY NUMBER
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If you have no insurance, please give the name, address, and telephone number of the responsible person.

NAME	PHONE NUMBER	
STREET ADDRESS		APARTMENT
CITY	STATE	ZIP

## Legal Status

ARE YOU CURRENTLY ON PAROLE, PROBATION, UNDER BOND, OR ORDERED BY THE COURT TO BE HERE? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, how long and for what? _____		
PAROLE/PROBATION OFFICER	PHONE NUMBER	
STREET ADDRESS		APARTMENT
CITY	STATE	ZIP

## **About Yourself**

Briefly answer the following questions.

1. What is the main problem, as you see it? What brings you to Alpha Acres?

2. What have you done about it?

3. What can we do? What are your expectations in coming here?

4. As you see yourself, what kind of person are you? Describe yourself.

5. Is there any other information that we should know about you?

## Criteria for Admission

1. Applicants must possess a willingness to submit to Alpha Acres rules and policies, a desire to change, and an openness to staff input and advice.
2. Applicants must demonstrate sufficient physical and mental ability, as well as a good attitude.
3. Applicants must have a responsible adult sponsor (see following page).
4. Applicants must produce evidence of a current Tuberculosis and HIV test or be tested before acceptance into the program.
5. Applicants cannot use smokeless tobacco of any kind.
6. Applicants must be willing and able to pass a drug screen before admittance to the program.
7. Applicants are required to write a separate, one-page essay answering the following:
  - a. What were you doing prior to coming to Alpha Acres?
  - b. Why did you choose to come here?
  - c. What do you hope to accomplish or gain here?

Once you have completed the application for the Transformers Program, please mail it to:

ATTN: Program Director  
Alpha Acres Christian Recovery Center  
PO Box 2120  
Yadkinville, NC 27055

You may also fax the application to 336.463.4741, to the attention of The Program Director.  
You will be contacted when your application is received.

My signature indicates that I am coming on my own free will. I hereby agree to cooperate in the program and abide by all rules. I do assume risks that might be incidental to my stay, and 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 Alpha Acres or the Winston-Salem Rescue Mission. I also give Alpha Acres and the Winston-Salem Rescue Mission permission to release information and/or records as the occasion arises.

I have read this application, and I accept the conditions as set forth by the Winston-Salem Rescue Mission. I also acknowledge 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

The resident's sponsor is responsible for assuring that:

1. the resident has the necessary AIDS (HIV) and Tuberculosis (TB) tests.
2. the resident has transportation to and from Alpha Acres and/or Winston-Salem Rescue Mission.
3. If a situation arises in which the student cannot or does not desire to complete the program, the sponsor is responsible for picking him up.
4. no alcohol or drugs are in the student's belongings upon arrival.
5. the resident has all needed items such as clothing, etc.
6. the resident brings a copy of the Bible with him.
7. the resident brings any proper/necessary prescription drugs or written prescriptions. Students should be "detoxed" prior to arrival. (They should **not** need antidepressants, sedatives, etc., once they are here since WE ARE NOT A MEDICAL FACILITY.)

**SPONSOR'S AGREEMENT: "I take responsibility for all of the above items as this resident's sponsor."**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE NUMBER (\_\_\_\_) \_\_\_\_\_ SIGNATURE \_\_\_\_\_