



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.

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

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) _____
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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)

What is your religious or denominational affiliation? _____

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? Yes 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 must be willing and able to pass a drug screen before admittance to the program.
6. 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?
7. The cost of this program is \$1,200.00. A non-refundable deposit of \$200 is required at check-in. The balance is to be paid in monthly installments of at least \$100.00, with the first payment due at the end of the first 30 days in residence.

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 336.232.1687, 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. no alcohol or drugs are in the student's belongings upon arrival.
4. the resident has all needed items such as clothing, etc.
5. the resident brings a copy of the Bible with him.
6. the resident brings any proper/necessary prescription drugs or written prescriptions. Residents should be "detoxed" prior to arrival. (They should **not** need antidepressants, sedatives, etc., once they are here since WE ARE NOT A MEDICAL FACILITY.)

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 within 6 hours**. If the sponsor is unable to do so due to distance or other factors, then he/she must pay for a bus ticket departing from Yadkinville, NC.

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

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____