180 MINISTRIES – WOMEN & WOMEN WITH CHILDREN

TEEN CHALLENGE OF THE RM

Student Application for Program Admission

Phone: 970-323-6013 | Fax: 970-323-9853
deb@180women.net

PERSONAL DATA AND INFORMATION

Last Name:____________________First Name:_________________________MI:________

Street Address:_______________________City:______________ST:________ZIP: ________

Home Phone: (______)_____________________Work: (______)_____________________Sex at Birth☐ Male ☐ Female Weight:________Height:________Hair Color:__________Eye Color:__________

Social Security Number:__________-_______-__________Birth Date:________________Age:__________

Driver's License Number: ________________ State: _______ Is D/L: Valid ____ Suspended ____ Expired ______

EMERGENCY CONTACT

Full Name:______________________________Relationship: ____________________

Street Address:_______________________City:______________ST:________ZIP: ________

Home Phone: (______)_____________________Work: (______)_____________________

WHO HAS REFERRED YOU TO TEEN CHALLENGE?

Full Name:______________________________Relationship: ____________________

Street Address:_______________________City:______________ST:________ZIP: ________

Home Phone: (______)_____________________Work: (______)_____________________

RACE / ETHNIC BACKGROUND (Please check only one)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Latino / Hispanic

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other______________________________

Are you a United States citizen? ☐ Yes ☐ Native ☐ Naturalized ☐ No Explain: ____________________

____

PERSONAL FAMILY HISTORY

List parents/parenting figures, spouse, girl/boyfriend, brothers and sisters (do not include your children)*:

Name	Relationship	Age	Residence	Phone

(Use the back of this page if additional space is required.)

Check the word that best describes your relationship with your parents as a child and now:

CHILD: ☐ Very Good ☐ Good ☐ Average ☐ Fair ☐ Poor

NOW: ☐ Very Good ☐ Good ☐ Average ☐ Fair ☐ Poor

Are your parents still living? Father ☐ Yes ☐ No Mother ☐ Yes ☐ No

Are you adopted: ☐ Yes ☐ No Were you raised by anyone other than your parents ☐ Yes ☐ No If yes, please explain: ______________________________

When did you last see your parents? ______________________________

When did you last live at home? ______________________________

Father's Occupation: ____________________ Mother's Occupation: ____________________

Parent's marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Remarried ☐ Living Together

If married, how long? ____________________ If other, how long? ____________________

How would you rate their marriage? ☐ Very happy ☐ Happy ☐ Average ☐ Unhappy

Growing up, who did you feel closest to? ☐ Father ☐ Mother ☐ Other: ____________________

How would you rate your childhood? ☐ Good ☐ Fair ☐ Poor Why? ____________________

____

Check any of the following words that best describe you now:

☐ Active	☐ Ambitious	☐ Self-confident	☐ Persistent	☐ Nervous	☐ Hard-working
☐ Impatient	☐ Impulsive	☐ Moody	☐ Often Blue	☐ Excitable	☐ Imaginative
☐ Calm	☐ Serious	☐ Easy-going	☐ Shy	☐ Good-natured	☐ Introvert
☐ Extrovert	☐ Likeable	☐ Leader	☐ Quiet	☐ Hard-boiled	☐ Submissive
☐ Self-conscious	☐ Lonely	☐ Sensitive	☐ Follower	☐ Easily influenced	☐ Valuable
☐ Worthless	☐ Angry	☐ Bitter	☐ Disillusioned	☐ Happy	☐ Other

Are you unsure which words best describe you? ☐ Yes ☐ No

Is it easy for you to express your feelings? ☐ Yes ☐ No ☐ Sometimes Explain: ____________________

____

Do you enjoy being with other people or would you rather be alone? Explain: ____________________

____

MARITAL / INTIMATE RELATIONSHIP HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed

List your present living arrangement: *(Please check all that apply)* ☐ Living alone ☐ With parents

☐ With spouse ☐ With others (non-relatives) ☐ With others (relatives, including children)

☐ Other:____________________

If you are, or have been married, please list: *(Start with your most recent marriage)*

Person Married To	Month/Year	Ended In (Divorce, Sep., Death)	Month/Year

Current Spouse's Full Name: ____________________

Street Address:________________City:__________ST:_____ZIP: _______

Home Phone: (_____)________________Work: (_____)________________

Describe your relationship with your spouse: ____________________

Do you have any children? ☐ Yes ☐ No If yes, please list:

Name Of Child	Age	Where Living

(Use the back of this page if additional space is required.)

Describe any positive or negative aspects of your relationship with your children: ____________________

Describe any problems or concerns related to your relationship with your spouse:____________________

Have you been sexually abused? ☐ Yes ☐ No When?__________By who? __________

How old were you?_______Were there multiple instances? ☐ Once ☐ Several times ☐ Ongoing

Do you still have contact with this person? ☐ Yes ☐ No____________________

To your knowledge, has anyone in your family ever been sexually abused? ☐ Yes ☐ No

Who:____________________By who: ____________________

Sexual Lifestyle: *(Please check all that apply)*

☐ Bisexual ☐ Heterosexual ☐ Homosexual ☐ Pornography ☐ Prostitution

Any recently involved?____________Have you ever engaged in homosexual activities? ☐ Yes ☐ No

Explain: ____________________

MILITARY SERVICE HISTORY

Have you ever served in the US Armed Forces? ☐ Yes ☐ No If yes, describe: ______________________

Branch of Service:______________________Entry Date:________________Discharge Date: ______________

Military occupation standing (MOS):______________________Rank attained: ______________________

Discharge received: ☐ Honorable ☐ Less than Honorable ☐ Dishonorable ______________________

Eligible for VA medical benefits? ☐ Yes ☐ No ☐ Unknown ______________________

LEGAL HISTORY

Are you legally mandated to participate in a Teen Challenge type program? ☐ Yes ☐ No

If yes, by whom? ☐ Parole Board ☐ Court ☐ Other (explain): ______________________

If answer is "Court" please list county of origin:______________________

Are you currently or will you be under legal supervision? ☐ Yes ☐ No

Method of reporting: ☐ Phone ☐ Letter ☐ In Person (explain): ______________________

How often do you report?________________How long?______________Time remaining: ______________

Probation or Parole Officer's Name: ______________________

Agency:______________________Phone number:______________________

Street Address:______________________City:________________ ST:________ZIP: ____________

Is any of the following pending against you? *(Please check those that apply)*

☐ Arrest warrant ☐ Court appearance ☐ Criminal charges ☐ Sentencing ☐ Other

If you have checked any of the above, please explain: ______________________

____

____

(Use the back of this page if additional space is required.)

List all arrests and convictions:

Date	Charges	Conviction (Y/N)	Sentence	Time in Jail	Drug Related? (Y/N)

(Use the back of this page if additional space is required.)

Have you ever been in prison? ☐ Yes ☐ No If yes, provide info below:

Date ______________ Institution ______________________

______________ ______________________

______________ ______________________

______________ ______________________

FINANCIAL STATUS

If you enter our program, what provisions will be made for the following expenses?

Medical:______________________________

Dental:______________________________

Are you eligible for and/or receiving the following:

☐ Welfare ☐ Disability payments ☐ Unemployment compensation ☐ Workman's compensation

☐ Other income (explain):______________________________

Have you ever applied for food stamps? ☐ Yes ☐ No Where? ____________________

Do you have any outstanding debts? ☐ Yes ☐ No Explain below:

Owed to	Amount	Address	Phone	Payment

SIGNIFICANT LIFE EVENTS

Describe any of the following that you are experiencing or have recently experienced:

Moves:______________________________

Losses (personal, financial):______________________________

Physical abuse/neglect: ______________________________

Foster home placement or institutionalization: ______________________________

Ethnic/cultural influences: ______________________________

Pregnancies: ☐ Yes ☐ No How many? ____________________

Results of pregnancies (check all that apply): ☐ Birthed Child ☐ Aborted ☐ Miscarried ☐ Adopted

Other (explain): ______________________________

____

ACADEMIC HISTORY

List the highest grade that you have completed: ____________________

Are you currently in an education program? ☐ Yes ☐ No If yes, name of school: ____________________

____________________City of school:____________________

If you are no longer in an education program, please explain your reason for leaving school:____________________

____

Are you receiving or have you received vocational training? ☐ Yes ☐ No If yes, list: ____________________

Type of Trade/Skills	Date of Training (MO/YR to MO/YR)	Certificate Issued (Y/N)

Can you read? ☐ Yes ☐ No ☐ Good ☐ Average ☐ Poor

Can you write? ☐ Yes ☐ No ☐ Good ☐ Average ☐ Poor

Describe your future educational goals and plans: ______________________________

____

Describe your future vocational training goals and plans: ______________________________

____

OCCUPATIONAL HISTORY

What is your vocational trade or profession, if any? ______________________________

How many jobs have you held in the last two years? ______________________________

List your present employment status:

☐ Unemployment *(Have not sought employment in the last 30 days)*

☐ Unemployment *(Have sought employment in the last 30 days)*

☐ Employed part-time *(Working less than 35 hours per week)*

☐ Employed full-time *(Working 35 hours or more per week)*

List your two most recent jobs: *(Start with your most recent job)*

Name of Employer	Position Held	Dates Employed (Mo/Yr to Mo/Yr)	Reason for Leaving

List your current average monthly income: ______________________________

Describe your future occupational goals and plans: ______________________________

____

Skills: ______________________________

____

Have you ever experienced or presently have a physical ailment, injury, or handicap that would prevent you from performing manual work-related tasks while you are enrolled in Teen Challenge? ☐ Yes ☐ No

If yes, explain: ______________________________

____

____

PSYCHOLOGICAL HISTORY

Have you ever received mental health treatment? ☐ Yes ☐ No If yes, please list:

Date	Name of Clinic	Reason for Mental Health Treatment	Outcome

(Use the back of this page if additional space is required.)

Has a family member or someone close to you ever attempted or committed suicide? ☐ Yes ☐ No

Have you ever thought about committing suicide? ☐ Yes ☐ No

Are you currently thinking about committing suicide? ☐ Yes ☐ No

Have you ever received psychiatric care? ☐ Yes ☐ No If yes, explain: ______________________________

____

Will you, as a student of Teen Challenge, be willing to authorize doctors or agencies involved in previous treatments to release your medical records? ☐ Yes ☐ No

INSURANCE INFORMATION

List your health insurance type: *(Please check)* ☐ No health insurance ☐ Medicaid/Medicare ☐ Other private insurance ☐ Other public funds ______________________________

Insurance policy number: ______________________________

Company: ______________________________ Phone: ______________

PERSONAL / FAMILY MEDICAL HISTORY

Please check the appropriate box for any family member that has experienced any of the following problems:

	Grandparent	Father	Mother	Spouse	Brother	Sister	Child
Drug Abuse							
Alcoholism							
Physical problems							
Mental health problems							

Describe any illness and/or developmental problem or concern you experienced as a child: ______________

____

Describe any previous and current medical conditions: ______________________________

____

List all medications you are currently taking: ___

___

___

Allergies? ☐ Yes ☐ No___

Have you ever struggled with ☐ Anorexia ☐ Bulimia ☐ Abusing self (cutting) ☐ Abusing others ☐ Sex ☐ Pornography ☐ Gambling ☐ Over-eating ☐ Stealing ☐ Video Games ☐ Work-a-holic If yes, explain:

___

___

Do you feel that you are addicted to any kinds of foods? If yes, explain: ___

Cigarette packs smoked per day. ___Our policy is no smoking or tobacco use, are you willing to abide by this policy? ___

List how often you used the following drugs:

	Never	Once	Several Times	Regularly	Daily
Alcohol					
Benzos (Valium, Xanax, etc.)					
Amphetamines (Adderall, Ritalin, etc.)					
Opiate Painkillers (oxy, Roxy, Hydro, etc.)					
Heroin					
Methamphetamine (Ice, Glass, Gravel, etc.)					
MDMA (Ecstasy, Molly, etc.)					
Marijuana					
Synthetic Marijuana (Spice, K2, etc.)					
Hallucinogenic (Mushrooms, LSD, etc.)					
Methadone, Suboxone, etc.					
Cocaine (Crack)					
Cocaine (Powder)					
Cold Medication (DXM, Triple C, etc.)					
PCP (Sherm, Angel Dust, etc.)					
Kratom					
IV use of any drug (please specify):					
Others (please specify):					

Present physician's name:___Phone number___

Street Address:___City:___ST:___ZIP: ___

SPIRITUAL HISTORY

Are you born again? ☐ Yes ☐ No Date:____________________Place:____________________________

What is your current spiritual condition?____

What were the circumstances that led to this? ____________________________________

____

Denominational preference? ____

How often do you attend church? ☐ Never ☐ Occasionally ☐ Regularly

Are you a member of any church or religion? ☐ Yes ☐ No If yes, which church/religion? ________________

How often did you attend church as a child?____

What denomination was it?____________________How old were you when you stopped attending?__________

Why did you stop attending? ____

Do you believe in God? ☐ Yes ☐ No ☐ Uncertain Do you pray? ☐ Never ☐ Occasionally ☐ Often

Do you read books of other religions instead of the Bible? ☐ Never ☐ Occasionally ☐ Often

Which ones? ____

What recent changes have you had in your religious life (if any)? ______________________________

____

Have you ever been involved in cults, such as Christian Science, Jehovah's Witness, Mormonism, Scientology, TM, Eastern Religions, or others? ☐ Yes ☐ No Explain: ____________________________________

____

THE PROBLEM

What is your main problem, as you see it? ____

____

____

What have you done about it?____

____

What are your greatest needs in order of priority? ____________________________________

____

Have you ever been in a program before? ☐ Yes ☐ No Was it: ☐ Religious ☐ Non-religious

How many programs have you been in before? ______________________________________

List the programs:

Program Name	Dates	Reason for Leaving

(Use the back of this page if additional space is required.)

Have you ever been in a Teen Challenge program before? ☐ Yes ☐ No

When?____________________ Where?____________________

Why did you leave the program? ☐ Dismissed by staff ☐ Left on your own ☐ Completed the program

☐ Graduated ☐ Other____________________

Why do you wish to be admitted? ____________________

What are you expecting (believing) God to do in your life through the program?____________________

Describe what you are willing to do, or what you think is required of you: ____________________

What would you like to do after you leave Teen Challenge?____________________

The undersigned student applicant fully acknowledges that the information provided herein is accurate and true to the best of his or her knowledge, and that the applicant form has been completed and filled out by student applicant in his or her own handwriting. Student applicant further understands that any false or incomplete information may cause and result in disqualification from admittance into the program, whether a student is just entering into or is in fact in the program.

Student Applicant Signature Date

If the enclosed application form has been completed or filled out by anyone other than the student applicant, please provide the following:

1. Name of person completing and filling out application form: ____________________
2. Relationship to applicant:____________________ Date: ____________________
3. Explain why student applicant was unable to complete or fill out the enclosed application form:____________________

TELL US ABOUT YOU

Please give us a chronological , bio sketch about who you are, your childhood, any major issues you have had or are now having. This may include your schooling/education, your relationship with your parents, step parents, siblings, etc. We would like to know anything you would like to tell us about who you are:

CHILD INFORMATION FORM

Children must be 0-5 years of age to accompany their mother into the program.

Fill out one form for each child. Make additional copies if necessary.

Attach a birth certificate, immunization records and custody papers (if applicable) for each child.

Name (last, first) ________________________________ SS # _______________ Date of Birth _____________

Sex (M or F) ____________ Age _______________ Hair Color _______________ Eye Color ______________

Who does the child live with at this time? Name ______________________ Phone # ( ) _________________

Address ____

What are the current custody arrangements? ____

Father's Name ____ Phone # ( )________________

Address (City, State, Zip) ____

If Child Protective Services is involved in the care of this child, please explain.

____

____

If the child has any medical problem, please explain.

____

____

Doctor's Name ____ Phone # ( ) _________________

List all allergies ____

If the child has any medical problem, please explain.

____

List all current medications and why they are prescribed.

____

Please provide any additional information important to the care of this child (History of abuse, trauma, behavioral problems, etc.)

____

____

PHYSICAL EXAM

Physician's Assistant, Nurse Practitioner , or Medical Doctor must complete everything on this page and sign at the bottom.

Name ______________________________ Date of Birth ____________ SS # ___________________

Present illnesses/complaints/disabilities, if any:

____

____

Allergies ____

Medications currently prescribed and reason for use:

____

____

Has client been exposed to any communicable disease? Yes _____ No _____ If yes specify. ______________

Past history of chronic or major illness, including operations, hospitalizations and resperations:

____

____

REQUIRED LAB WORK

Hepatitis B & C____
V.D.R.L. ____
HIV ____
Pregnancy ____
T.B. Skin Test _____________________________ Chest X-Ray (if T.B. positive) _______________

General Comments, assessments or recommendations on above:

____

Doctor's Name __________________________ Doctor's Signature ______________________________

Address ____

Phone # _____________________ Fax # _____________________ Date of Exam __________________

Applicant's Physical and Health Exam: Passed ____________________ Failed ____________________
(Examining Personnel circle one)

Teen Challenge of the Rocky Mountains
P.O. Box 784 Olathe, CO 81425
PH 970-323-6013 Fax 970-323-9853

Dear Potential Sponsor

____________________________ has applied for entry into the 180 Ministries – Women and Women with Children program. This Teen Challenge program is a residential program for individuals with life controlling problems such as drug and/or alcohol addiction and abuse. To see more information about our program you may go to 180ministries.net.

Teen Challenge is an international, non-denominational, faith based program. It is a nationally accredited program which is financially an entity of its own and governed by a local board of directors. It is not underwritten by any organization or agency. Teen Challenge is registered under 501(c) (3) allowing all sponsorship donations to be tax deductible.

Each student is asked to acquire sponsors to underwrite cost of the program. This shows her interest and desire in seeking rehabilitation. Sponsors can be family, friends, churches, businesses or other concerned individuals. It costs approximately $2,400.00 per month to maintain a student and her child(ren) in the program. We depend on each student and her family to assist us in securing her portion of this cost.

If you are interested in investing in a life, please indicate on the sponsorship form below your commitment to Teen Challenge and return with payment to the above address.

Name ____________________________ Address ____________________________City ___________________

State ______ Zip _______ Phone (   ) _______________ Email ______________________________________

I will give $_________ Montly _________ One Time Gift _________ for _______________ while she is in the program. Future montly payments may be sent to 7750 6025 Road – Olathe, CO 81425

Please enclose a check or set up your online giving at 180ministries.net by following the attached giving instructions.

SPONSORSHIP FORM

Name and address of prospective sponsors that sponsorship letters were given to:

Name ______________________ Relationship to Student ______________________

Address ______________________ City ____________ State________ Zip __________

Name ______________________ Relationship to Student ______________________

Address ______________________ City ____________ State ________ Zip __________

Name ______________________ Relationship to Student ______________________

Address ______________________ City ____________ State ________ Zip __________

Name ______________________ Relationship to Student ______________________

Address ______________________ City ____________ State ________ Zip __________

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Name ______________________ Relationship to Student ______________________

Address ______________________ City ____________ State ________ Zip __________