

*Admission Procedure  
Reconciliation House Inc.*

Criteria for Admission

Dear applicant:

Upon your admission to RHI, you will need to provide the following:

- Must be at least eighteen years of age
- Must be willing to not pursue any romantic relationships (heterosexual or homosexual) .
- Must be willing to make a commitment of at least *one year*.
- Must be willing to quit use of *NICOTINE*
- Medical Exam
- Certified Birth Certificate
- School Immunization Record
- Social Security Card
- Results of a recent physical exam indicating you Have no physical limitations or ongoing health Problems which would interfere with your participation in the Personal Development Program
- Results of a recent TB screening
- Mental Health evaluation
- All personal business must be taken care of prior to admission
- Signed release from previous establishment.

You will need to contact the following agencies, if you are admitted to RHI:

- AFDC
- DFACS
- Food Stamp office

Admission Process

- Complete an application
- Meet with Social Services Coordinator for an interview
- Establish an arrival date.
- Clients not appropriate for the program will be given appropriate referrals.
- Clean Drug Screen

*Initial contact is usually via telephone. The Coordinator conducts a brief interview. The potential client is then asked to come to Reconciliation House to complete an application. It is not always possible for the caller to come to Reconciliation House, in these cases; we can mail or fax the application and a program description.*



Reconciliation House Inc.

**Women Aftercare Service  
Release of Information Consent Form**

I \_\_\_\_\_, authorize \_\_\_\_\_

To: \_\_\_\_\_ (send) \_\_\_\_\_ (receive) the following \_\_\_\_\_ (to) \_\_\_\_\_ (from) the following agencies of people:

Name	Address	City/State/Zip	Phone

<input type="checkbox"/> Academic Testing Results	<input type="checkbox"/> Psychological Testing Results
<input type="checkbox"/> Behavior Programs	<input type="checkbox"/> Service Plans
<input type="checkbox"/> Case Notes	<input type="checkbox"/> Summary Reports
<input type="checkbox"/> Intelligence Testing Results	<input type="checkbox"/> Vocational Testing Results
<input type="checkbox"/> Medical Reports	<input type="checkbox"/> Entire Record
<input type="checkbox"/> Personality Profiles	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Progress Reports	
<input type="checkbox"/> Psychological Reports	
The above information will be used for the following purposes:	
<input type="checkbox"/> Planning appropriate Treatment Program	
<input type="checkbox"/> Continuing appropriate Treatment or Program	
<input type="checkbox"/> Determining Eligibility for Benefits or Program	
<input type="checkbox"/> Case Review	
<input type="checkbox"/> Updating Files	
<input type="checkbox"/> Other (specify)	

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose and who will receive the information.

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

(If client is unable to sign)

Signature of Person Informing Client of Rights \_\_\_\_\_ Date \_\_\_\_\_

**Please mail to:**

Reconciliation House Inc. P O Box 2983 Stockbridge, Georgia 30218

Reconciliation House Inc.  
P O Box 2983  
Stockbridge, Georgia 30281  
Phone -478 787 4215  
Fax-706.472.3031

## Application for Admission

Name \_\_\_\_\_ Age \_\_\_\_\_

Social Security Number \_\_\_\_\_

Current Address: \_\_\_\_\_

Phone number \_\_\_\_\_ Can we leave a message for you at this number? \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Hair \_\_\_\_\_ Eye Color \_\_\_\_\_

Race/Ethnic Group: Caucasian \_\_\_\_\_ Black \_\_\_\_\_ Hispanic \_\_\_\_\_ Asian \_\_\_\_\_ Other \_\_\_\_\_

Religious Affiliation \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone#: \_\_\_\_\_

Have you ever been here before? \_\_\_\_\_

What circumstance led to your present homeless situation? \_\_\_\_\_

Why are you applying to Reconciliation House Inc. at this time? \_\_\_\_\_

What are your immediate needs? \_\_\_\_\_

What are your present goals? \_\_\_\_\_

What are your strengths \_\_\_\_\_?

What are your weaknesses? \_\_\_\_\_

Can arrangements be made for a responsible party to care for your child (ren) for six months to a year?  
\_\_\_\_\_

Who is this person/relationship? \_\_\_\_\_



List any medications taken in the last three years:

Medication	Reason	Dates

Have you had any major surgery in the last five years? \_\_\_\_\_ If yes explain: \_\_\_\_\_

Is there any chance you could be pregnant? \_\_\_\_\_ How many months? \_\_\_\_\_

Pregnancy complications: \_\_\_\_\_

Have you ever had an abortion? \_\_\_\_\_ If yes how many? \_\_\_\_\_

**EDUCATIONAL/VOCATIONAL HISTORY**

Highest grade level completed \_\_\_\_\_ Do you have a GED? \_\_\_\_\_ Are you a veteran? \_\_\_\_\_

Vocational programs entered and/or completed: \_\_\_\_\_

**EMPLOYMENT HISTORY:**

Last place of employment: \_\_\_\_\_

When was the last time you worked? \_\_\_\_\_

Did you quit or where you fired? /explain \_\_\_\_\_

**HOUSING/CREDIT HISTORY**

Last place of residence \_\_\_\_\_

Reason Left \_\_\_\_\_

Are you currently homeless? \_\_\_\_\_ If so, how long? /why \_\_\_\_\_

Have you ever received housing assistance? \_\_\_\_\_ If so from whom? \_\_\_\_\_

Do you presently owe the Housing Authority any money? \_\_\_\_\_ If so how much? \_\_\_\_\_

Do you have any outstanding debts? (Loans, credit cards, bills) \_\_\_\_\_

Was any action taken? \_\_\_\_\_

LEGAL HISTORY

Any pending charges? \_\_\_\_\_ Any alias?/ Pending charges?

\_\_\_\_\_

Violation

Date

Have you ever been arrested?/ Alias? \_\_\_\_\_ If yes how many times? \_\_\_\_\_

Date	Charge	Sentence/Requirements

Are you on probation /parole? \_\_\_\_\_ If yes:

Name, address, telephone number of probation/parole officer: \_\_\_\_\_

\_\_\_\_\_

Did you see a Chaplain or Counselor while incarcerated? \_\_\_\_\_ If yes:

Name, Address, telephone number: \_\_\_\_\_

\_\_\_\_\_

MEDICAL HISTORY

Date of last physical \_\_\_\_\_

Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_

Are you currently under medical supervision? \_\_\_\_\_

Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_

Have you ever had any of the following?

\_\_\_ Seizures      \_\_\_ Heart Disease      \_\_\_ Diabetes      \_\_\_ Vision Problems

\_\_\_ Respiratory Problems      \_\_\_ Venereal Disease      \_\_\_ Hepatitis      \_\_\_ Hearing Problems

\_\_\_ Tuberculosis      \_\_\_ Other

If you checked any of the above, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been in therapy? \_\_\_\_\_

Therapist	Type of Therapy	Dates

Were medications prescribed? \_\_\_\_\_ If yes describe (medication, dates): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Family Psychiatric history? \_\_\_\_\_ If yes describe (medication, dates): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been physically, emotionally, or sexually abused?

Type of abuse/age	Abuser/Relationship	Present Involvement

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

For the safety, and the safety of the community, are you willing to make sure this person does not know you are here? \_\_\_\_\_ Have you ever talked with anyone about this experience? \_\_\_\_\_ Was any action taken against the abuser? \_\_\_\_\_

Have you ever been stalked by anyone? \_\_\_\_\_ Are you currently being stalked? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Has your child(ren) ever witnessed the abuse? \_\_\_\_\_

Has your child(ren) ever been abused? \_\_\_\_\_

Child/Type of Abuse	Abuser/Relationship	Present Involvement

If so, have you ever talked to anyone about your child's abuse? \_\_\_\_\_

Age at first use \_\_\_\_\_ Longest Period of sobriety \_\_\_\_\_

Drug of Choice \_\_\_\_\_

Previous 28 day or residential treatment centers:

Name of Program 1. \_\_\_\_\_ Date Discharged \_\_\_\_\_

2. \_\_\_\_\_ Date Discharged \_\_\_\_\_

Outpatient Treatment:

Name of Program 1. \_\_\_\_\_ Date Discharged \_\_\_\_\_

2. \_\_\_\_\_ Date Discharged \_\_\_\_\_

Have you ever sought treatment for an eating disorder? \_\_\_\_\_ Explain \_\_\_\_\_

Reconciliation House is a nicotine-free program. Do you smoke? \_\_\_\_\_ If yes, are you willing to quit? \_\_\_\_\_

**SUICIDAL**

Have you ever attempted suicide? \_\_\_\_\_ If yes, how many times?

Date	Circumstances	Treatment/Date

Current suicidal thoughts? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**MENTAL HEALTH TREATMENT**

Has hospitalizations for nerves or emotional reasons been necessary? \_\_\_\_\_

Name	Dates	Chief Complaints

**INCOME**

Are you currently receiving welfare or government aid? \_\_\_\_\_

Specific kind and amount \_\_\_\_\_

Name and office of case worker: \_\_\_\_\_

Other income source(s) \_\_\_\_\_ Amount \_\_\_\_\_

Any additional comments you wish to make: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reconciliation House Inc. is not a medical or psychiatric facility. Therefore, prospective clients must be medically, as well as psychiatrically cleared prior to admission. The requested medical information is vitally important and is required before a decision can be made as to the appropriateness of our facility for prospective clients. If mental health evaluation/documentation is requested, that also must be received before a final decision can be made on placement in the Reconciliation House. If, after admission it is noted that the client is inappropriate due to medical and or psychiatric reasons about which we were uninformed prior, Reconciliation House reserves the right to refer the client to another facility or back to the referring agency.

\_\_\_\_\_

Signature

Date

## Reconciliation House Inc. Policies

"I am saying this for your own good, not to restrict you, but that you may live in a right way in undivided devotion to the Lord." (1 Corinthians 7:35)

1. *Program clients are expected to refrain from any cursing, dirty jokes or gossip. (James 1:26)*
2. *Clients are asked to dress in a conservative manner (i.e. No undergarments showing, no mid-drifts, miniskirts, short - shorts, no t - shirts advertising alcoholic beverages or cigarettes or with offensive or suggestive prints). Bras are required. Something must be worn on your feet at all times. Slippers are allowed to be worn in the building after the evening activities and before breakfast. (Timothy 2:9-10)*
3. *All clients are expected to keep their rooms clean and neat. Clients are not to eat food or drink beverages in their room. (1 Corinthians 14:33)*
4. *All clients are given a job responsibility and supervisor and are expected to adhere to the responsibilities of that job. (Colossians 3:23-24)*
5. *All clients recognize that nicotine is an addictive substance and have made a commitment to quit smoking completely upon entering the program. No smoking paraphernalia is allowed (i.e. lighters, matches, etc.). (1 Corinthians 6:19-20)*
6. *Practicing good hygiene is encouraged and appreciated. (1 Corinthians 6:19-20)*
7. *Keeping up with prescribed physical and mental health medications and appointments is required. Medication must be taken as prescribed on the bottle. Any changes must be made by a doctor's written consent.(1 Corinthians 6:19-20)*
8. *TV hours are 8:30 pm - 9:30 pm on weekdays. No personal TV's are allowed in rooms. No personal radios are allowed, there will be monitoring of the music that is listened to and television that is viewed. (1 Corinthians 6:12)*
9. *No poker, blackjack, lottery playing or other gambling is allowed. (Colossians 3:2-5)*
10. *Clients who are found continually stirring conflicts among the community will be dismissed. (Romans 12:18 and Romans 14:19)*
11. *No drugs are allowed unless prescribed by a physician and administered during medication times. No mood altering drugs (codeine, valium, etc.) are allowed. No mouthwash, cough syrup or medication containing alcohol is allowed. All medications must be kept in the office including over-the-counter medication. Random drug screens will be taken on all clients.(1 Peter 4:1-3)*
12. *Clients are required to abstain from all forms of sexual activity (heterosexual and homosexual) and are not allowed to pursue any romantic relationships while participating in the program. Clients will also not be allowed to "pair off into emotionally dependent relationships. No contact with men (visits, phone calls or letters) will be allowed unless approved by the counselor. (1 Thessalonians 4:3-6)*
13. *No pornographic material is allowed. (Proverbs 4:23 and Matthew 5:27-28)*

## **GROUNDS FOR DISMISSAL**

1. DRINKING ALCOHOL, SMOKING CIGARETTES AND/OR USING DRUGS.
  2. BREAKING MEDICATION POLICIES.
  3. REFUSING TO FOLLOW REFERRALS FROM YOUR CASEWORKER.
  4. REFUSING TO FOLLOW THE POLICIES!!!
  5. DISHONESTY (INCLUDING "SITTING ON SECRETS").
  6. CONTINUAL HOSTILE ATTITUDE AND/OR DISRESPECT TOWARD STAFF MEMBERS, CLIENTS OR VOLUNTEERS.
  7. FAILURE TO SIGN IN AND OUT OF THE BUILDING.
  8. STEALING
  9. VIOLENCE OR THREATS OF VIOLENCE OR POSSESSION OF ANY TYPE OF WEAPON
  10. STIRRING CONFLICTS AMONG THE COMMUNITY.
  11. BEING IN A ROOM OR BATHROOM OTHER THAN THE ONE YOU ARE ASSIGNED.
  12. SEXUAL SUGGESTIONS, ADVANCES AND ACTIONS.
  13. THE STAFF HAS THE RIGHT TO DISMISS A CLIENT IF, FOR ANY REASON, THE STAFF BELIEVES THE CLIENT IS NOT SERIOUSLY COMMITTED TO WORKING THE RECOVERY PROGRAM.
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### **COMMITMENT**

***I HAVE READ THESE POLICIES, UNDERSTAND THEM AND AGREE TO ABIDE BY THEM***

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**CLIENT SIGNATURE**

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**DATE**

(Ecclesiastes 5:4-5)

**COMMITMENT TO THE RECONCILIATION HOUSE INC.**

I understand that the Reconciliation House is a difficult program that requires me to be motivated and physically active. I am willing to make a whole-hearted commitment to participate fully in this program.

I will provide Reconciliation House Inc. with a medical statement indicating that I have no physical limitations which would interfere with my complete participation in the community service portion of the program. This means that there is nothing that hinders my ability to sweep, mop, rake, or do normal household chores or yard work. In addition, I will be tested for tuberculosis. Results of this test will be forwarded to Reconciliation House Inc. I may also be required to have a mental health evaluation. Results of this evaluation will be forwarded to Reconciliation House Inc as well.

I recognize my need for long-term help and I am willing to commit to at least nine months of involvement in the program.

I understand this is a nicotine-free program and that smoking cigarettes is strictly prohibited. I also understand that smoking while I am a program client is grounds for dismissal.

I agree not to pursue any romantic relationships (heterosexual or homosexual) while participating in the re-entry program.

I have read the rules and agree to abide by them. I agree to follow them while living here. I am aware that if I choose to violate them or not work the reentry program, and/or hurt the community I may be asked to leave.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date