Resident Application

Admission Criteria

- Women over the age of 18 who are survivors of human sex trafficking.
- Potential residents must:
  - Express a desire to commit to the program and to their treatment and healing.
  - Be ambulatory.
  - Be able to perform basic self-help activities, such as eating and bathing.
  - Have the ability to care for their own possessions to maintain bedroom and living area in a reasonable state of orderliness and cleanliness.
  - Be able to recognize danger or threat to personal safety.
  - Have the ability to live comfortably within any limitations in the structure of the facility.
  - Be generally able to maintain appropriate behaviors tolerable to the community.
  - Be willing to submit to and pass regular and random drug testing.
  - Have already received emergent care, as we are not an emergency/temporary shelter and we are not a detoxification facility.
  - Sign all required documents upon intake.
- RSM is unable to provide services for women who are severely hearing impaired or severely visually impaired.
- RSM is unable to provide services to women with outstanding warrants.
- RSM is unable to provide services to women who are registered sex offenders.
- RSM is unable to admit women who are currently using or abusing substances. Residents with such a history must already be in recovery and have 30 days clean in order to be considered for admittance into RSM. **Residents must pass a drug screen at intake.**
- RSM may not be equipped to provide the necessary care for women with severe and/or pervasive mental illness. Potential residents will be asked to disclose their mental health history, including prior counseling, diagnoses, medications, and hospitalizations. All admittance decisions will be made on a case by case basis by RSM staff.
- Potential residents will be asked to disclose any medical conditions, as RSM may not be equipped to adequately assist individuals with severe health/medical conditions.
- RSM is unable to admit women who are currently pregnant. **A pregnancy test will be conducted at intake.**
- Women who currently have custody of their child(ren) must make provisions for their child(ren) to be in temporary custody with a trusted party while at RSM. RSM is willing to assist in this process. RSM will assist in making arrangements for approved visitations with child(ren).
- A fully completed application is required. Incomplete applications will not be considered. Women will be asked to disclose information regarding their history and experience, including substance abuse and mental health information, in order for staff to determine if RSM is able to best meet their needs. Once the application is submitted, staff will thoroughly review it to determine the potential resident's eligibility for the program. If it is determined that the applicant meets initial criteria, an applicant interview will be conducted to determine if RSM is an appropriate fit. If a decision is reached to invite the applicant into the program, the applicant will then be contacted by RSM staff for additional instructions regarding the move in process. If not admitted to the program, appropriate referrals will be given. Throughout this process, RSM staff will make every effort to provide follow-up and feedback in a timely manner.
- **Background checks will be done on all who apply to the RSM program.**

- Providing false information on this application may result in dismissal from the RSM program.
- In order to provide the best care possible, RSM reserves the right to use discretion when making admission decisions.

Date of referral: ________________ Referred by: ____

First Name:_______________________ Middle:_______________________ Last:_______________________
Other Names/Street Names/Nicknames/Maiden Used: ____
____
DOB: ________________ Age: ________ Ethnicity: ◻Hispanic ◻Non-Hispanic ◻Don't Know
Race: ◻ Caucasian / White ◻Black / African American ◻Hispanic/Latina
◻American Indian/Alaska Native ◻Native Hawaiian/Pacific Islander ◻Asian
Gender Identity: ◻Male ◻Female ◻Trans ◻Other Gender at Birth: ◻Male ◻Female
Sexual Orientation: ◻Bisexual ◻Gay ◻Unsure ◻Heterosexual ◻Lesbian
Are you a U.S. Citizen? ◻Yes ◻No Social Security Number: ____________________________________

Do you currently have a Case Manager? If yes, please provide name and phone number:
____

Most Recent Mailing Address and Cell Phone Number: ____
____
Email Address: ____
Are you currently homeless? ◻Yes ◻No Do you own a vehicle? ◻Yes ◻No
Current Living Situation: ____
Safe Telephone Number: _________________________ Is it safe to leave messages? ◻Yes ◻No
Alternate Contact Name and Phone: ____
Relationship to Alternate: ____

Relationship History

Relationship Status (Select all that apply):
◻ In a Relationship ◻ Single ◻ Married ◻ Separated ◻ Divorced ◻ Widowed ◻ Cohabitating
Have you been in a romantic relationship in the past 60 days? ◻Yes ◻No If yes, please describe: ____
Do you have children ? ◻Yes ◻No
If yes, please list 1) ages and 2) where they are currently living (location & with whom):
____
____
Where do you consider "home"? State: __________________ County: __________________

What was your family structure growing up? "I was raised…" (Select all that apply):
◻ By my two biological parents ◻ In foster care ◻ In institutional care
◻ By a single biological parent ◻ By adoptive parent(s)
◻ By my grandparent(s) or other relative(s) ◻ Other ____________________________

Education and Employment

Are you currently employed? ◻Yes ◻No If yes, where? ____

☐Full-Time ☐Part-Time Description of Responsibilities: ______________________
Previous job experience? ☐Yes ☐No If yes, where? ______________________

____
Description of Responsibilities: ______________________

Are you in school?: ☐Yes ☐No
If yes, where? ______________________ ☐Full-Time ☐Part-Time
What is your highest level of education: ______________________
Are you interested in further education? ☐Yes ☐No
If yes, please explain: ______________________
When you were in school did you receive special learning services or have an IEP (individualized education plan)? ☐Yes ☐No If yes, please explain: ______________________

Trafficking/Prostitution History

Do you consider yourself a trafficking survivor? ☐Yes ☐No
Please briefly explain your trafficking experience: ______________________
____
____
Have you ever sold or traded sex for money, drugs, goods, or services? ☐Yes ☐No
If yes, please explain: ______________________
At what age did you first receive anything of value in exchange for sex?______________________
Have you ever been forced or coerced to engage in sexual activity for money, drugs, goods, or services? ☐Yes ☐No
If yes, please explain: ______________________
Have you ever forced or coerced someone else to engage in sexual activity for money, drugs, goods, or services? ☐Yes ☐No
If yes, please explain: ______________________
Have you ever been trafficked outside the U.S.? ☐Yes ☐No
If yes, where? ______________________

Were you recruited into trafficking as a minor? ☐Yes ☐No Age at first entry:______________
Month and year entered into trafficking:______________ How long have you been free from trafficking? (Month / Year):______________
At what age did you first receive anything of value in exchange for sex, if ever:______________

How recently was the trafficking situation?
☐ Currently happening ☐1-3 months ago ☐4-6 months ago ☐ 7-12 months ago
☐ Over a year ago

Do you currently have a pimp/“daddy”/trafficker/“boyfriend”? ☐Yes ☐No
Have you ever had a pimp/“daddy”/trafficker/“boyfriend”? ☐Yes ☐No
If yes, please describe: ______________________
Is the trafficker currently a threat? ☐Yes ☐No ☐Unsure

Through which venues have you been exploited? (Select all that apply)
☐ Streets ☐ Houses ☐ Hotels ☐ Escort Agencies ☐ Brothels/Massage Parlors
☐ Out calls ☐ Bars ☐ Casinos ☐ Truck Stops ☐ Sugaring
☐ Stripping/exotic dancing ☐ Camming ☐ Pornography ☐ Internet based/Websites
☐ Conventions/Sporting Events ☐Other ______________________

Have you ever been forced to take drugs or drink alcohol? □Yes □No

Have you ever been subjected to the following?

Sexual Abuse	□Yes □No	As a child?	□Yes □No
Physical Abuse	□Yes □No	As a child?	□Yes □No
Rape	□Yes □No	As a child?	□Yes □No
Psychological Abuse	□Yes □No	As a child?	□Yes □No
Verbal Abuse	□Yes □No	As a child?	□Yes □No
Neglect	□Yes □No	As a child?	□Yes □No
Occult / Ritualistic Abuse	□Yes □No	As a child?	□Yes □No

Have you ever been in a trauma based program for trafficking survivors? □Yes □No
If yes:

When? ______________________ Where? ______________________________________
When? ______________________ Where? ______________________________________
When? ______________________ Where? ______________________________________
When? ______________________ Where? ______________________________________

Would you be willing to sign a Release of Information for RSM to speak with previous program(s)? □Yes □No

Drug and Alcohol History

Do you currently use tobacco products? □Yes □No If yes, which ones?
Cigarettes □Yes □No Cigars □Yes □No E-cigs □Yes □No Vapes □Yes □No
Chewing tobacco □Yes □No Other: ____
Are you currently using or abusing drugs (including marijuana), alcohol, or any other substance? □Yes □No If yes, please list: ____
Do you have a history of drug or alcohol abuse? □Yes □No
Do you have a history of drug or alcohol dependence / addiction? □Yes □No
How long have you currently been sober? _________________ Date of last use: ____________
How long was your longest amount of time sober? _______________ When? _______________
If yes, what is/was your drug of choice?

□ Alcohol	□ Hallucinogens	□ Heroin
□ Marijuana	□ Methamphetamines	□ Narcotics
□ Prescription Drugs	□ Barbiturates	□ Other __________________
□ Opiates	□ Crack/Cocaine	□ N/A

Are you currently receiving Medication Assisted Treatment (MAT) for opioid or alcohol addiction? □Yes □No
If yes, which form? □ Vivitrol/Naltrexone □ Suboxone/Buprenorphine □ Methadone

Which drug(s) do you frequently use? How often? Method of use (IV, snort, smoke, oral)?
□ Alcohol – How often? ______________________________________ Method ______________
□ Marijuana – How often? ____________________________________ Method ______________
□ Prescription Drugs – How often? ____________________________ Method ______________
□ Opiates – How often? ______________________________________ Method ______________
□ Hallucinogens – How often? _________________________________ Method ______________
□ Methamphetamines – How often? ____________________________ Method ______________
□ Barbiturates – How often? __________________________________ Method ______________

☐ Crack/Cocaine – How often? ______________________ Method ____________
☐ Heroin – How often? ______________________ Method ____________
☐ Other – How often? ______________________ Method ____________

Have you ever been in drug or alcohol treatment? ☐Yes ☐No If yes:

When? ______________ Where? ______________________
When? ______________ Where? ______________________
When? ______________ Where? ______________________
When? ______________ Where? ______________________

What kind of treatment, if any, have you tried? (Select all that apply.) ☐ N/A
☐Inpatient ☐ Counseling ☐ Medication ☐ Group
☐Outpatient ☐ 12 Step AA/NA Meetings ☐ Other: ____________

Do you struggle with any of the following forms of addictive behavior?
☐ Gambling ☐ Pornography ☐ Co-dependency
☐ Money ☐ Sex / Masturbation ☐ Phone/internet/social media
☐ Nicotine/Smoking ☐ Shopping ☐ Other: ____________

Medical History and Information

Do you have any current medical problems? ☐Yes ☐No
If yes, please explain: ______________________________________

Are you currently under the care of a physician? ☐Yes ☐No
Name: ______________________ Phone: ______________
Address: ______________________________________
City: ______________________ Zip: ______________

Please list any prescribed medications for your **physical health** you are currently taking **(**Mental Health medications will be listed in a separate section)**:
Medication: ______________________ Dose: ______________
Reason: ______________________________________
Medication: ______________________ Dose: ______________
Reason: ______________________________________
Medication: ______________________ Dose: ______________
Reason: ______________________________________
Medication: ______________________ Dose: ______________
Reason: ______________________________________

Please list any other prescribed medications for your **physical health** you have taken in the last six months:
Medication: ______________________ Dose: ______________
Reason: ______________________________________
Medication: ______________________ Dose: ______________
Reason: ______________________________________
Medication: ______________________ Dose: ______________
Reason: ______________________________________
Medication: ______________________ Dose: ______________
Reason: ______________________________________

Are you prescribed, or do you take, any THC products? (CBD, Cannabis, Delta, etc.)
◻Yes ◻No If yes, please describe: ______________________________

Are you experiencing or have you experienced any of the following?

◻ Chest Pains	◻ Headaches	◻ Nausea & Vomiting
◻ Sweats	◻ Liver Problems	◻ N/A
◻ Seizures	◻ Loss of Consciousness	

Are you: Visually Impaired? ◻Yes ◻No If yes, please explain: ______________
Hearing Impaired? ◻Yes ◻No If yes, please explain: ______________
What was the date of your last physical? ______________
Are you pregnant? ◻Yes ◻No ◻Unsure / It's possible
Do you have any disabilities? ◻Yes ◻No
If yes, please explain: ______________
Do you have any dental needs? ◻Yes ◻No
If yes, please explain: ______________
Do you have any allergies? ◻Yes ◻No
If yes, please explain: ______________
Do you have any symptoms as a result of drug/alcohol use or abuse? ◻Yes ◻No
If yes, please explain: ______________
Have you experienced trauma to the head (hitting your head, hair pulling, etc.)? If yes, please explain: ______________
Do you feel like you need medical treatment at this time? ◻Yes ◻No
If yes, please explain: ______________

Have you ever been tested for any of the following?

◻ Hepatitis A	Date of last test: __________	Result: __________
◻ Hepatitis B	Date of last test: __________	Result: __________
◻ Hepatitis C	Date of last test: __________	Result: __________
◻ Tb	Date of last test: __________	Result: __________
◻ HIV	Date of last test: __________	Result: __________

Are you currently being treated for any of the above? ______________
Do you have any chronic medical conditions? (High BP, Thyroid, Diabetes, Epilepsy, Insulin Dependent, Seizures, etc.) ◻Yes ◻No If yes, please describe: ______________
____
Have you ever been hospitalized? ◻Yes ◻No
If yes, when? Please explain: ______________
____
Have you had any surgeries or medical procedures? ◻Yes ◻No
If yes, when? Please explain: ______________
Do you have medical insurance? ◻Yes ◻No
If yes, with whom: ______________

Mental Health Status

Have you ever been treated for a psychiatric problem? ◻Yes ◻No If yes, when? __________
If yes, please explain: ______________
Do you have a history of an Eating Disorder? ◻Yes ◻No If yes, when? __________

☐Anorexia ☐Bulimia ☐Binge-Eating ☐ Compulsive Overeating
Received treatment:____

Do you have a history of self-harm / cutting? ☐Yes ☐No If yes, when? ____________________
Please explain: ____
Have you ever attempted suicide? ☐Yes ☐No Approximate Date of Last Attempt: __________
If yes, please explain: ____
Have you ever been hospitalized for a psychiatric issue? ☐Yes ☐No If yes, when? _________
If yes, what was the issue:____

Do you have a mental health diagnosis? ☐Yes ☐No
If yes, what are the diagnoses?____
If yes, when was the diagnosis made? ____
Do you agree with your mental health diagnosis? ☐Yes ☐No ☐ N/A
If no, please explain: ____
Have you been prescribed medication associated with this diagnosis? ☐Yes ☐No ☐ N/A
If not, are you open to taking prescribed medication for this diagnosis? ☐Yes ☐No ☐ N/A

If you are currently taking prescribed medication for **mental health** diagnoses, please list:

Medication: ________________________________ Dose: ____________________
Reason: ____
Medication: ________________________________ Dose: ____________________
Reason: ____
Medication: ________________________________ Dose: ____________________
Reason: ____
Medication: ________________________________ Dose: ____________________
Reason: ____

Do you receive any of the following:
TennCare / Medicaid Benefits? ☐Yes ☐No
WIC Assistance? ☐Yes ☐No
Social Security Benefits? ☐Yes ☐No
SNAP / Food Stamps? ☐Yes ☐No
TANF / Families First? ☐Yes ☐No
Child Support Payments? ☐Yes ☐No
Other: ☐Yes ☐No Please Explain: ____
If yes, what is the amount? ____

Legal Information

Do you have any past or current criminal charges? If yes, please describe charges and include approximate dates: ____
____

Was there a conviction for any of these charges? ☐Yes ☐No

Have you ever been incarcerated? ☐Yes ☐No
If yes, dates: ___________________________ Length of incarceration: _________________

Are you currently incarcerated? ☐Yes ☐No Place: ____________________________________
If yes, explain/ charges: ____
____
Sentence: ___________________________ Scheduled Release Date: ______________

What was your living situation prior to being incarcerated? ☐N/A

____

____

Do you have outstanding warrants in any states/counties? ☐Yes ☐No
If yes, please explain, including offense: ____________________________________

____

Do you have any pending charges? ☐Yes ☐No
Charge: ______________________ Place: ___________________ Date: __________
Charge: ______________________ Place: ___________________ Date: __________

Are you currently on parole or probation? ☐Yes ☐No
If yes, what state and county? ____
Are you currently on federal parole or probation? ☐Yes ☐No
If yes, explain: ____

____

Parole/Probation Officer: ____

Stipulations required for parole/probation: _____________________________

____

____

Are you required to complete a program by the Court/Probation or Parole? ☐Yes ☐No

Is there an open case against a trafficker? ☐Yes ☐No If yes, describe case against trafficker:

____

Do you have a history of acting out in violence? ☐Yes ☐No
If yes, please describe: ____

____

Are you a registered sex offender? ☐Yes ☐No
If yes, please explain: ____

____

Have you ever been in a gang or have any gang or organized crime group affiliations?
☐Yes ☐No If so, when? _______ Which one(s): ______________________________
Please describe current / past involvement and/or exit:

____

____

Do you have any outstanding court/probation fees? ☐Yes ☐No If yes, to whom and how much is owed? ____

Have **you** ever abused, neglected, or maltreated a child/minor? ☐Yes ☐No
If yes, please explain: ____
Have **you** ever been convicted of a crime against a child/minor? ☐Yes ☐No
If yes, please explain: ____
Do **you** currently have or do you expect to have an open case involving a child? ☐Yes ☐No
If yes, please explain: ____

____

Goals, Needs, Strengths, and Interests

Why do you wish to participate in Rest Stop Ministries' residential program?
____
____

What has led up to you wanting to be a part of this program? ___________________
____
____

When you imagine yourself graduating from this program, what do you want to look back on as your accomplishments? ____
____

Do you have any goals that you would like to share with us?
____
____

Needs: Tell us about any specific needs that you might have while at RSM?
____
____

When it gets hard, what is going to keep you from quitting on yourself? ____________
____

Strengths and Abilities: Tell us about the positive characteristics and/or natural skills that you possess.
____
____

Interests and Hobbies: Tell us about any interests you have or hobbies that you enjoy.
____
____

Is there anything else that you would like us to know about you?
____
____
____

I certify that information in this application is true and complete to the best of my knowledge. I understand that the completion of this application does not guarantee acceptance into the Rest Stop Ministries residential program. By my signature below, I authorize RSM to perform a criminal history record check relative to my application into the RSM program.

_____________________________________ ________________

Applicant Signature Date