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:_____
DOB: _____ Age: _____ Race: _____ Gender: □Male □Female
Gender at Birth: □Male □Female Sexual Preference: _____
Other Names/Street Names/Nicknames/Maiden Used: _____
_____
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: _____
_____
Email Address: _____
Are you currently homeless? □Yes □No
Current Living Situation: _____
Safe Telephone Number: _____ Safe to leave messages? □Yes □No
Alternate Contact Name and Phone: _____
Relationship to Alternate: _____
Relationship Status:
□ In a Relationship □ Single □ Married □ Divorced □ Widowed □ Cohabitating
Do you have children ? □Yes □No
If yes, please list 1) ages and 2) where they are currently living:
_____
_____

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: _____

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: _____
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:_____
Ages and length of time trafficking was experienced: _____
_____
How long have you been free from trafficking? _____
Do you currently have a pimp/"daddy"/trafficker/"boyfriend"? □Yes □No
Have you ever had a pimp/"daddy"/trafficker/"boyfriend"? □Yes □No
Have you ever been forced to take drugs or drink alcohol? □Yes □No
Places trafficked/prostituted:
□Streets □Houses □Hotels □ Agencies □ Massage Parlors
□Out Call □Casinos □Bars □ Online □Other _____

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
Ritual 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? _____

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, alcohol, or any other substance? □Yes □No
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

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? (Check all that apply.) □ N/A

□Inpatient	□ Counseling	□ Medication	□ Group
□Outpatient	□ 12 Step AA/NA Meetings		□ Other: _____

Legal Information

Have you ever been incarcerated? □Yes □No
If yes, please explain / charges:_____
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
_____
_____

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: _____
Circumstances required for parole/probation: _____
_____
_____
Do you have outstanding warrants in any states/counties? □Yes □No
If yes, please explain: _____
_____
Do you have any pending charges? □Yes □No
Charge: _____ Place: _____ Date: _____
Charge: _____ Place: _____ Date: _____

Do you have a history of violence? □Yes □No
If yes, please explain: _____
_____

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:
_____
_____

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: _____
_____

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:
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 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
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: _____
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, etc.) _____
_____
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: _____
Have you ever been hospitalized for a psychiatric illness? □Yes □No If yes, when? _____
If yes, please explain:_____
Have you ever attempted suicide? □Yes □No If yes, when? _____
If yes, please explain: _____
Do you have a history of an Eating Disorder or self-harm/cutting? □Yes □No If yes, when? _____
If yes, please explain: _____
Do you have a mental health diagnosis? □Yes □No
If yes, please explain: _____
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
SNAP / Food Stamps? □Yes □No
WIC Assistance? □Yes □No
TANF / Families First? □Yes □No
Social Security Benefits? □Yes □No
Child Support Payments? □Yes □No
Other: □Yes □No Please Explain: _____
If yes, what is the amount? _____

Goals, Needs, Strengths, and Interests

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

_____
_____

What do you hope to gain from residency in the program?

_____
_____

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?

_____

_____

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