



## 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: _____ <hr/> DOB: _____ Age: _____ Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Don't Know Race: <input type="checkbox"/> Caucasian / White <input type="checkbox"/> Black / African American <input type="checkbox"/> Hispanic/Latina <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans <input type="checkbox"/> Other Gender at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female Sexual Orientation: <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay <input type="checkbox"/> Unsure <input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No Social Security Number: _____
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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

Current Living Situation: \_\_\_\_\_

Safe Telephone Number: \_\_\_\_\_ Safe to leave messages? Yes No

Alternate Contact Name and Phone: \_\_\_\_\_

Relationship to Alternate: \_\_\_\_\_

Relationship Status (Check all that apply):

In a Relationship  Single  Married  Separated  Divorced  Widowed  Cohabiting

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 recently was the trafficking situation?

Currently happening  1-3 months ago  4-6 months ago  7-12 months ago

Over a year ago – 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

Is the trafficker currently a threat? Yes No Unsure

Places trafficked/prostituted:

Streets Houses Hotels Agencies Massage Parlors

Out Call Casinos Bars Online 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?

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Alcohol            | <input type="checkbox"/> Hallucinogens    | <input type="checkbox"/> Heroin      |
| <input type="checkbox"/> Marijuana          | <input type="checkbox"/> Methamphetamines | <input type="checkbox"/> Narcotics   |
| <input type="checkbox"/> Prescription Drugs | <input type="checkbox"/> Barbiturates     | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Opiates            | <input type="checkbox"/> Crack/Cocaine    | <input type="checkbox"/> 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)?

- |  |              |
|--|--------------|
| <input type="checkbox"/> Alcohol – How often? _____            | Method _____ |
| <input type="checkbox"/> Marijuana – How often? _____          | Method _____ |
| <input type="checkbox"/> Prescription Drugs – How often? _____ | Method _____ |
| <input type="checkbox"/> Opiates – How often? _____            | Method _____ |
| <input type="checkbox"/> Hallucinogens – How often? _____      | Method _____ |
| <input type="checkbox"/> Methamphetamines – How often? _____   | Method _____ |
| <input type="checkbox"/> Barbiturates – How often? _____       | Method _____ |
| <input type="checkbox"/> Crack/Cocaine – How often? _____      | Method _____ |
| <input type="checkbox"/> Heroin – How often? _____             | Method _____ |
| <input type="checkbox"/> 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

- |                                     |   |                                       |                                |
|-------------------------------------|---|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Inpatient  | <input type="checkbox"/> Counseling             | <input type="checkbox"/> Medication   | <input type="checkbox"/> Group |
| <input type="checkbox"/> Outpatient | <input type="checkbox"/> 12 Step AA/NA Meetings | <input type="checkbox"/> 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 in 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 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: \_\_\_\_\_

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?

<input type="checkbox"/> Hepatitis A	Date of last test: _____	Result: _____
<input type="checkbox"/> Hepatitis B	Date of last test: _____	Result: _____
<input type="checkbox"/> Hepatitis C	Date of last test: _____	Result: _____
<input type="checkbox"/> Tb	Date of last test: _____	Result: _____
<input type="checkbox"/> 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

Other: Yes No Please Explain: \_\_\_\_\_

If yes, what is the amount? \_\_\_\_\_

SNAP / Food Stamps? Yes No

TANF / Families First? Yes No

Child Support Payments? Yes No

## 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:

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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: \_\_\_\_\_

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## Goals, Needs, Strengths, and Interests

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

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What has led up to you wanting to be a part of this program? \_\_\_\_\_

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

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

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

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

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

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

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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