

Vision of Hope Ministries  
Resident Application

***The confidential information you share on this application will not be held against you or used to judge you. Vision of Hope staff simply needs to know the facts about you and where you are in life right now. Please remember that we will not be able to help you if you are not completely honest when you answer the questions below. Please understand that we absolutely cannot review this application if anything is left blank. If you do not understand what is being requested, please call us and we will be happy to assist you. If a question does not apply it is very important that you mark N/A.***

**Prior** to filling out this application you **must** have read and understand each of the following documents. Please initial next to each document to indicate you have done so.

_____ Applicant Cover Letter	_____ Eating at VOH
_____ What You Can Expect to Learn	_____ The Time Commitment
_____ Expectations for Residents	_____ Daily Schedule
_____ Medication & Medical Appt Policies	_____ Visitor Policy
_____ Application Process Overview	_____ Integrity Commitment

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Present Address:** \_\_\_\_\_  
Street Address City State Zip

Is this your permanent address? \_\_\_\_\_ (If not, please list your permanent address below)

**Permanent Address:** \_\_\_\_\_  
Street Address City State Zip

Telephone # ( ) \_\_\_\_\_ Cell Phone # ( ) \_\_\_\_\_

Work # ( ) \_\_\_\_\_ Message Phone # ( ) \_\_\_\_\_

Please describe your current living arrangements: \_\_\_\_\_  
\_\_\_\_\_

All email addresses where you may be reached: \_\_\_\_\_  
\_\_\_\_\_

Are you on Facebook? \_\_\_\_\_ Under what names? \_\_\_\_\_

Are you active on Twitter? \_\_\_\_\_ Under what usernames? \_\_\_\_\_

Are you active on any blogs / chat rooms / support group websites? (list websites and usernames)  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever applied to Vision of Hope in the past? \_\_\_\_\_ If yes, please give the date \_\_\_\_\_

**Your Main Problems** (check all that apply)

- Unplanned Pregnancy
- Anorexia
- Bulimia
- Other Eating / Body Image Disorder

- Self-harm
- Drug Abuse
- Drug Addiction
- Other: \_\_\_\_\_

**Summary of your current situation:**

Why would you like to come to Vision of Hope? \_\_\_\_\_

Why is a faith-based treatment center the best approach for you? \_\_\_\_\_

What are you hoping to gain while at Vision of Hope? \_\_\_\_\_

List your 5 biggest goals in coming to Vision of Hope

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

List your 5 biggest fears in coming to Vision of Hope

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Referral Source:**

- |  |                                    |                                    |                                      |
|--|------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Social Services | <input type="checkbox"/> Courts    | <input type="checkbox"/> Parents   | <input type="checkbox"/> Church      |
| <input type="checkbox"/> Self            | <input type="checkbox"/> Probation | <input type="checkbox"/> Counselor | <input type="checkbox"/> Other _____ |

Name of the person who referred you: \_\_\_\_\_

Contact Info the person who referred you Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**Information About You**

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

City and State of Birthplace: \_\_\_\_\_

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

Driver's License Number and expiration date: \_\_\_\_\_

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

**Spiritual Background**

Do you feel that you have a need for God? \_\_\_\_\_ Explain: \_\_\_\_\_

\_\_\_\_\_

What is your present relationship with God? \_\_\_\_\_

\_\_\_\_\_

Have you committed your life to following God? \_\_\_\_\_

Date: \_\_\_\_\_ Place: \_\_\_\_\_

Are you a member of any church or religion? \_\_\_\_\_

Denominational background: \_\_\_\_\_

Where do you attend church? \_\_\_\_\_ How often? \_\_\_\_\_

Do you read the Bible? \_\_\_\_\_ How often? \_\_\_\_\_

Do you ever pray? \_\_\_\_\_ How often? \_\_\_\_\_

Have you ever witnessed or been involved with occult activities? (Satan worship, Ouija boards, levitation, rituals, séances, sacrifices, spiritism, voodoo, witchcraft, etc) \_\_\_\_\_

If yes, explain each \_\_\_\_\_

\_\_\_\_\_

Have you ever been abused in any of these activities? \_\_\_\_\_

Have you ever been involved in any of the following cults?

\_\_\_\_\_ Christian Science

\_\_\_\_\_ Mormonism

\_\_\_\_\_ Eastern Religions

\_\_\_\_\_ Scientology

\_\_\_\_\_ Jehovah's Witness

\_\_\_\_\_ Kabbalah

\_\_\_\_\_ Brotherhood

\_\_\_\_\_ New Age Mvmnt

\_\_\_\_\_ Transcendental  
Meditation

Write a brief explanation of your involvement with each: \_\_\_\_\_

Do your family and friends describe themselves as Christians? \_\_\_\_\_

Denomination and name of family's church: \_\_\_\_\_

**Family Relationships**

Describe how you get along with your family \_\_\_\_\_

# of siblings you have? \_\_\_\_\_ sisters \_\_\_\_\_ brothers \_\_\_\_\_ step / half sisters \_\_\_\_\_ step / half brothers

Are you adopted? \_\_\_\_\_ Describe your reaction to being adopted: \_\_\_\_\_

**If you are a minor:**

Name of Parent / Guardian: \_\_\_\_\_

Guardian Address: \_\_\_\_\_

Telephone # ( ) \_\_\_\_\_ Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email: \_\_\_\_\_

**Intimate Relationships / Marital Status**

\_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Engaged \_\_\_\_\_ Serious Relationship

If you are married, is your husband in agreement with you applying to VOH? \_\_\_\_\_

Are you seeking marital counseling right now? \_\_\_\_\_ Where? \_\_\_\_\_

Are you currently seriously dating anyone? \_\_\_\_\_

**Pregnancy**

Are you pregnant? \_\_\_\_\_ Approximate Due Date: \_\_\_\_\_ Has a Dr confirmed it? \_\_\_\_\_

Is the birth father aware of your pregnancy? \_\_\_\_\_

What involvement do you anticipate the birth father having with you during your pregnancy? \_\_\_\_\_

What are you considering for your child? parenting \_\_\_\_\_ adoption \_\_\_\_\_

*Vision of Hope believes in allowing you to make the choice between adoption and parenting. As a part of that decision making process, Vision of Hope will urge every pregnant single woman to carefully consider whether adoption may be the most loving option for her unborn child. If you resident chooses to place her baby for adoption, Vision of Hope does have an Adoption Ministry to assist her with choosing a Christian family for her child if she would like.*

**Children**

Do you have any children? \_\_\_\_\_ How many? \_\_\_\_\_

List names and ages of all children you have given birth to:

- 1. \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_
- 2. \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_
- 3. \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_
- 4. \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Who has custody of your children? \_\_\_\_\_

What arrangements are being made for your children while you are at Vision of Hope? \_\_\_\_\_

Are you on any type of government or financial assistance? \_\_\_\_\_

Will coming to Vision of Hope have any effect on this assistance? \_\_\_\_\_

**Friendships**

Do you find that you are able to make and keep friends easily? \_\_\_\_\_

How well do you resolve conflict and deal with problems in relationships? \_\_\_\_\_

Do you get along well with people in general? \_\_\_\_\_

Do you struggle with any of the following?: (check all that apply)

- |                             |                                       |                          |
|-----------------------------|---------------------------------------|--------------------------|
| _____ Outbursts of anger    | _____ Physical violence toward others | _____ Aggression         |
| _____ Isolation             | _____ People pleasing                 | _____ Codependency       |
| _____ Quiet simmering anger | _____ Bitterness / Unsolved Problems  | _____ Jealousy of others |

**Overall Physical and Medical Health**

Are you in general good health? \_\_\_\_\_

Do you have any medical problems? \_\_\_\_\_

List any physical limitation that you may have as indicated by a physician: \_\_\_\_\_  
 \_\_\_\_\_

Reason: \_\_\_\_\_

Do you have any conditions or events in your past that would limit your ability to fully participate in the standard VOH program? \_\_\_\_\_  
 \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_ List: \_\_\_\_\_  
 \_\_\_\_\_

List any and all medication that you take:

Medication	Dosage	For what reason?	For how long?

List all past surgeries or medical hospitalizations (include dates): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Eating Habits**

Do you consider your eating habits to be normal or abnormal? \_\_\_\_\_

Have you ever experienced any of the following behaviors / conditions?

- |                    |                      |                       |
|--------------------|----------------------|-----------------------|
| _____ anorexia     | _____ bingeing       | _____ over exercising |
| _____ purging      | _____ laxative abuse | _____ diet pill abuse |
| _____ feeding tube | _____ gluttony       | _____ other (_____)   |

Are you on a special diet? \_\_\_\_\_ Explain: \_\_\_\_\_  
 \_\_\_\_\_

If yes, was this diet prescribed by a Doctor? \_\_\_\_\_ Dr.'s name and phone # \_\_\_\_\_

Do you eat meat? \_\_\_\_\_

Do you have any **medically verifiable** food allergies? \_\_\_\_\_

If you have, or have ever had, a problem with food or eating, please explain in detail: \_\_\_\_\_

If you have been diagnosed with an eating disorder or treated by a physician for an eating disorder,

please explain in detail: \_\_\_\_\_

Dr.'s name and phone # \_\_\_\_\_

**Past and Current Substance Abuse**

Have you ever experimented with the following substances? (Mark those that apply by writing in the date that you last used that substance.)

- |                              |                                       |                |                 |
|------------------------------|---------------------------------------|----------------|-----------------|
| _____ Alcohol                | _____ Hallucinogenic (Acid, LSD, etc) | _____ Morphine | _____ Inhalants |
| _____ Crank                  | _____ Amphetamines (Uppers)           | _____ Opiates  | _____ Crack     |
| _____ Crystal Meth           | _____ Barbiturates (Downers)          | _____ Heroin   | _____ Tobacco   |
| _____ Marijuana              | _____ Meth Amphetamines               | _____ Cocaine  | _____ Ecstasy   |
| _____ Other (Specify: _____) |                                       |                |                 |

Drugs of Choice:

1. \_\_\_\_\_ Frequency of use: \_\_\_\_\_ Date of last use? \_\_\_\_\_
2. \_\_\_\_\_ Frequency of use: \_\_\_\_\_ Date of last use? \_\_\_\_\_
3. \_\_\_\_\_ Frequency of use: \_\_\_\_\_ Date of last use? \_\_\_\_\_
4. \_\_\_\_\_ Frequency of use: \_\_\_\_\_ Date of last use? \_\_\_\_\_

Maximum habit cost per day? \_\_\_\_\_ Longest period clean? \_\_\_\_\_

Have you ever been in an alcohol, drug, or detox program before? \_\_\_\_\_

Was it faith based or secular? \_\_\_\_\_

Date of Entry	Program Name	City / State	Reason for Leaving	Date of Discharge

**Overall Psychological Health / Past Counseling or Treatment Experience**

Have you ever been diagnosed or treated for (please mark yes or no):

- |                                   |                              |                     |
|-----------------------------------|------------------------------|---------------------|
| _____ DID / Dissociative Disorder | _____ ADHD / ADD             | _____ Schizophrenia |
| _____ Bi-Polar Disorder           | _____ Borderline Personality | _____ PTSD          |
| _____ Severe Trauma in past       | _____ Depression             | Other (_____)       |

Have you ever experienced a life altering traumatic event that still affects your mental health? \_\_\_\_\_



**Sexual Health**

Are you sexually active? \_\_\_\_\_ Since what age? \_\_\_\_\_

Under what conditions? \_\_\_\_\_

Have you ever been a victim of sexual abuse? \_\_\_\_\_ physical abuse? \_\_\_\_\_ or ritual abuse? \_\_\_\_\_

Have you ever been a victim of rape? \_\_\_\_\_ or incest? \_\_\_\_\_ How old were you? \_\_\_\_\_

Have you ever been involved in prostitution? \_\_\_\_\_ For what reasons? \_\_\_\_\_

Have you ever been in an intimate relationship with another girl? \_\_\_\_\_ To what extent? \_\_\_\_\_

\_\_\_\_\_ When? \_\_\_\_\_ How many different relationships? \_\_\_\_\_

Have you ever contracted an STD? \_\_\_\_\_ Explain: \_\_\_\_\_

Have you ever tested positive for HIV / AIDS? \_\_\_\_\_ Explain: \_\_\_\_\_

**Educational Background**

Name of last school attended? \_\_\_\_\_

Dates of attendance? \_\_\_\_\_

Did you graduate? \_\_\_\_\_ If not, what was last grade completed? \_\_\_\_\_

Have you ever been in special education classes? \_\_\_\_\_ If yes, please list: \_\_\_\_\_

Do you have plans to further your education? \_\_\_\_\_

**Current Financial Status**

Do you have any outstanding debts? \_\_\_\_\_ Explain: \_\_\_\_\_

\_\_\_\_\_

What arrangements will you make for their payment while you are at VOH? \_\_\_\_\_

\_\_\_\_\_

Will the finances for your personal needs while at Vision of Hope be sponsored by a church, ministry,

family, or individual? \_\_\_\_\_ If yes, who? \_\_\_\_\_

***Vision of Hope provides food and shelter, but we are not responsible for medical expenses or prescriptions. It is the responsibility of parents or guardians of minors, or their sponsoring agency, to cover these expenses. Arrangements should be made prior to residency. If NONE of the above is available to you, please inform the intake coordinator during your interview.***

**Legal Background** Please make sure to send copies of all legal / court documents for all charges, open or closed.

Arrest History

Date	Charge	Legal Outcome	Current Status

Do you have any pending court dates? \_\_\_\_\_ Explain: \_\_\_\_\_

Are you currently incarcerated? \_\_\_\_ Total Sentence \_\_\_\_ Length of time remaining? \_\_\_\_\_

Name of Attorney or Legal Representative: \_\_\_\_\_

Telephone # (    ) \_\_\_\_\_

Have you ever been on probation or parole? \_\_\_\_\_ Are you now? \_\_\_\_\_

How long? \_\_\_\_\_ Length of time remaining: \_\_\_\_\_

How often do you report? \_\_\_\_\_ In person or through mail? \_\_\_\_\_

Name of probation or parole officer? \_\_\_\_\_

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

Telephone # (    ) \_\_\_\_\_

Is there anything else you feel the staff at Vision of Hope needs to know about you, your situation, or your application for residency?

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

I have read the rules of Vision of Hope and agree to submit to the rules and staff at Vision of Hope Ministries. I understand that if I have failed to answer these questions truthfully or purposely withheld information, it can be grounds for either refusal or dismissal from the program.

**Please include two 4 x 6 photos of yourself. One needs to be a head shot and one needs to be a full body head-to-toe shot. These do not need to be professionally taken.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date