

# Exodus Recovery Program

A ministry of City Gospel Mission

## Program Application

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

Prison ID#: \_\_\_\_\_

### GENERAL INFORMATION

Personal Information		
Name	Aliases	
Race/Ethnicity	Date of Birth	
SS#	Driver's License #	
Current Address	Length of Time	
City State ZIP		
Previous Address	Length of Time	
City State ZIP		
Phone	Message Phone	
Medicaid#	Religious Preference	
Church Home	Length of Time	

Marital Status	
<input type="radio"/> Single (Never Married)	
<input type="radio"/> Married	How Long
<input type="radio"/> Separated	How Long
<input type="radio"/> Divorced	How Long
<input type="radio"/> Widowed	How Long

Children		
Name	Date of Birth	Current Place of Custody
1.		
2.		
3.		
4.		
5.		

Emergency Contact	
Name	Relationship
Address	
Home Phone	Work Phone
Pager	Cellular Phone

**FAMILY HISTORY**

Parents' Name	Date of Birth	How Often Visited/Deceased
1.		
2.		
List Siblings (Brothers & Sisters)		
1.		
2.		
3.		
4.		
5.		
Significant Support Person		
1.		
2.		
3.		

**HOUSING** (Check One)

<input type="radio"/> Living Independently	How Long
<input type="radio"/> Living with Parents	How Long

**FINANCIAL**

<b>Current Income</b> (Indicate amount for each. Use zero if you receive no income. Do not leave blank.)	
AFDC	Social Security
Food Stamps	Salary
SSI	Worker's Comp

<b>Current Expenses</b> (Indicate amount for each. Use zero if you no expenses. Do not leave blank.)	
Rent	Storage
Child Support	Other

<b>Money Management</b>
How well do you manage your money?
<input type="radio"/> I do it independently and am not in debt.
<input type="radio"/> Someone assists me to get my bills paid on time.
<input type="radio"/> I can't do it at all and as a result I am in debt.

**MEDICAL HEALTH**

1. Do you currently have any health problems that require on-going treatment (surgery, medication, physical therapy...)?  Yes  No

If Yes, please indicate any **medical conditions / diagnosis** that you have:

_____	_____
_____	_____
_____	_____

Please list any medications you are currently taking:

Name of Medication	Dosage	Purpose of Medication	Outcome/Response of Treatment	Side Effects

2. Have you been hospitalized for medical problems in the past 2 years?  Yes  No

Name of Institution	Dates of Treatment	Name of Physician who administered treatment	Outcome/Response of Treatment

Does Exodus have permission to contact the institution/physician to coordinate treatment?

Yes No

**MENTAL HEALTH**

11. Have you received mental health services from any of the following?

Hospitals	<input type="radio"/> Yes	<input type="radio"/> No
Drug & Alcohol treatment programs	<input type="radio"/> Yes	<input type="radio"/> No
Residential programs	<input type="radio"/> Yes	<input type="radio"/> No
Transitional programs	<input type="radio"/> Yes	<input type="radio"/> No

12. Have you ever seen a counselor, psychiatrist, or physician for mental or emotional reasons (one time or ongoing)?

Yes  No

Name of Institution	Dates of Treatment	Name of Physician who administered treatment	Outcome/Response of Treatment

Does Exodus have permission to contact the institution/physician to coordinate treatment?

Yes    No																									
<p>13. Are you currently taking prescribed medication for mental health or emotional reasons?  <input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, please list the following information:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name of Medication</th> <th style="width: 10%;">Dosage</th> <th style="width: 30%;">Prescribing Physician</th> <th style="width: 15%;">Outcome/Response of Treatment</th> <th style="width: 15%;">Side Effects</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Does Exodus have permission to contact the institution/physician to coordinate treatment?  <input type="radio"/> Yes <input type="radio"/> No</p>	Name of Medication	Dosage	Prescribing Physician	Outcome/Response of Treatment	Side Effects																				
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***SUBSTANCE ABUSE HISTORY***

3. How many cigarettes do you smoke per day?					
4. Please circle which substances used and how often?					
Alcohol	Daily	1-3 times a week	monthly	2-4 times a year	never
Marijuana	Daily	1-3 times a week	monthly	2-4 times a year	never
Pills	Daily	1-3 times a week	monthly	2-4 times a year	never
Crack Cocaine	Daily	1-3 times a week	monthly	2-4 times a year	never
Heroin	Daily	1-3 times a week	monthly	2-4 times a year	never
Other	Daily	1-3 times a week	monthly	2-4 times a year	never
5. When was the last time you used drugs? <span style="float: right;">Alcohol?</span>					
6. What is your drug of choice?					
7. Do you continue to use any of these substances despite negative consequences (i.e. loss of job or relationships with friends and family?)    Yes    No					
Please indicate how drugs have impaired your life:					
_____					
_____					
_____					
_____					
8. Have you experienced any symptoms of withdrawal using any of the substances listed above?    Yes    No    If so, please list					
_____					
_____					
_____					
9. Circle the number which best describes your level of addiction.					
5 I am definitely addicted	4 I am probably addicted	3 I don't know if I am addicted	2 I am probably not addicted	1 I am definitely not addicted	

10. Have you ever received in- or outpatient treatment for drug or alcohol addiction?

Yes  No

If yes, please list the following information:

Name of Institution	Dates of Treatment	Name of Physician who administered treatment	Outcome/Response of Treatment

Does Exodus have permission to contact the institution/physician to coordinate treatment?

Yes No

**EDUCATION**

1. What was the last grade that you fully completed?		
2. Do you have a:		
GED	<input type="radio"/> Yes	<input type="radio"/> No
High School diploma	<input type="radio"/> Yes	<input type="radio"/> No
Trade School diploma	<input type="radio"/> Yes	<input type="radio"/> No
College diploma	<input type="radio"/> Yes	<input type="radio"/> No

**LEGAL**

1. Do you have any outstanding warrants? <input type="radio"/> Yes <input type="radio"/> No
2. Are you currently on probation or parole? <input type="radio"/> Yes <input type="radio"/> No
3. Do you have any pending court cases? <input type="radio"/> Yes <input type="radio"/> No
4. Have you been recently or are you currently incarcerated? Yes No Please list all offenses: _____ _____ _____
5. List any arrests and the outcomes in the past five years. _____ _____
6. Have you ever been convicted of a sex offence against a child? Yes No
7. What is your prospective release date?
8. Who is your case manager and what is their phone number? _____ _____
9. Who is your chaplain and what is their phone number? _____ _____

**SOCIAL SERVICES**

1. Have you ever been involved with Social Services for reasons other than financial assistance? o Yes o No
2. Are you currently involved with Social Services for reasons other than financial assistance? o Yes o No

*I understand that if I am accepted as a participant in this ministry, that falsification or absence of any information on this form is grounds for dismissal. I also understand that by signing this form I am giving the Exodus Program permission to contact the institutions listed in this form to coordinate treatment. I authorize the Exodus Program to release and/or receive copies of information concerning my treatment or hospitalization.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please return the completed application to:**

City Gospel Mission  
c/o Exodus Recovery Program  
1805 Dalton Avenue, Cincinnati, Ohio 45214  
513-345-1094

*Contact will be made in 72 hours. Please indicate a telephone number \_\_\_\_\_ and a time \_\_\_\_\_ you can be reached.*

*We look forward to meeting with you.*

*Lucreta Bowman, Vice President*