MAIL: WORTHY RECOVERY INC. (WRI)
PO Box 116, La Porte, IN 46352

WORTHY WOMEN RECOVERY HOME APPLICATION

MISSION: Worthy Recovery, Inc. (dba Worthy Women Recovery Home) is a Christian ministry that offers housing and education to women suffering from criminal thinking and/or substance abuse.

VISION/PURPOSE STATEMENT:
We love God, others, and ourselves, sharing and sustaining hope for life-long recovery. **Mark 12:30-31 NLT**

PLEASE READ AND SIGN HERE FIRST: **As a resident of WWRH, I will abstain from ALL COMMUNICATIONS regarding romantic and intimate relationships, as indicated by my signature:** ____

NOTE: *Your information may be used **anonymously** to create evidence and research-based demographics and crimino-genic data, to indicate the dire need for a recovery resources in our community. NO personal information will be used.*

PLEASE PRINT ALL INFORMATION (to ensure that your application can be read and reviewed)

APPLICANT INFORMATION

YOUR First, Middle and Last Name: ____ Date: ______________

Birthday (MM/DD/YEAR): ______/_______/___________ SSN: ____

DOC #: _________________________ Facility Name: ____

Address: ___________________________________ City: ______________________ State: _____ Zip Code: _________

Family Contact Name: ____ Relationship: ________________________

Phone: ___________________________________ City/State: ____

LEGAL INFORMATION

Are you a convicted sex offender: _______ County/State: _____________________________________ Year: ________

Are you a convicted violent offender: ______ County/State: ___________________________________ Year: ________

Do you have any felony conviction(s): _______

If yes, please list each one ***(do not list FTA or PO/Parole Violations.)*** on a separate line and the County/State:

____

____

____

____

Do you have any warrants? ________ County and State ____

List any pending court cases:

Charge____________________________________ County/State: ____

Charge____________________________________ County/State: ____

Charge____________________________________ County/State: ____

TRUSTING GOD

Did you attend church as a child? ________ As an adult? _______ Participating in Jail/Prison Bible Studies: ________

ANSWER ONE ONLY: Do you want to know about God? ________ Do you want to know MORE about God? _______

Write (print) a paragraph with a clear description of why you are willing to surrender to God:

____

____

____

____

Write (print) a paragraph describing why you think a personal relationship with Jesus is necessary to change your life:

____

____

____

____

Have you surrendered to Jesus Christ and asked him to be the Lord and Savior of your life? ________ Age: ________

DRIVING HISTORY

Status of your Driver's License: ________________________________ License #: ____________________________

Amount of reinstatement fees that you must pay: $___________________

Do you own a vehicle?: _________ License Plate Number: __________________________ State:_________________

Will you need help to obtain a Birth Certificate? ________ A Social Security Card? ________ A State ID? ________

RELATIONSHIP STATUS

What is your Relationship Status? ______ Married, ______Engaged, _____Divorced, _____Widowed, _____Single,

Spouse/Fiancés Name: First ______________________ Middle ___________________ Last _____________________

Is he a convicted _____violent _____sexual offender? County and State: ____________________________________

DO YOU HAVE CHILD(REN): ______Yes ______No

Name of Child(ren): Age: Who they live with: County/State of Residence:

____

____

____

____

FAMILY HISTORY (Include information for deceased members as well)

Do you know your father: _______ Is the relationship: Good _____ Bad ____ Have not seen him since: __________

History: Substance user: Y__ N__ Was incarcerated: Y___ N___ Is incarcerated: Y___ N___ Homeless: Y___ N___
He suffers with Mental Health Issues: Y___ N___ Receives Government Assistance: Y___ N___
Did he abuse, hurt, misuse, assault, or violate you as a Child: _______ **As a Teen:** _______ **As an Adult:** ________

Do you know your mother: _______ Is the relationship**:** Good _____ Bad ____ Have not seen her since: _________
History: Substance user: Y__ N__ Was incarcerated: Y___ N___ Is incarcerated: Y___ N___ Homeless: Y___ N___
She suffers with Mental Health Issues: Y___ N___ Receives Government Assistance: Y___ N___
Did she abuse, hurt, misuse, assault, or violate you as a Child: _______ **As a Teen:** _______ **As an Adult:** _______

Do you have a stepfather: ______ Is the relationship**:** Good _____ Bad_____ I don't really know him:___________
History: Substance user: Y__ N__ Was incarcerated: Y___ N___ Is incarcerated: Y___ N___ Homeless: Y___ N___
He suffers with Mental Health Issues: Y___ N___ Receives Government Assistance: Y___ N___
Did he abuse, hurt, misuse, assault, or violate you as a Child:_______ **As a Teen:** _______ **As an Adult:** ________

Do you have a stepmother: ______ Is the relationship**:** Good _____ Bad ____ I don't really know her: ___________
History: Substance user: Y__ N__ Was incarcerated: Y___ N___ Is incarcerated: Y___ N___ Homeless: Y___ N___
She suffers with Mental Health Issues: Y___ N___ Receives Government Assistance: Y___ N___
Did she abuse, hurt, misuse, assault, or violate you as a Child: _______ **As a Teen:** ______ **As an Adult:** ________

Name of sisters or brothers over 18 years old: **Felony Conviction: Yes/No** **Substance Abuse: Yes/No**

____

____

____

____

____

WORK HISTORY

List the last 3 jobs you have worked (types, not places): **Length of time:** **Reason for leaving:**

____

____

____

EDUCATION HISTORY (Include Graduating Year)

What year did you graduate High School:________________

What year did you drop out of High School:____________ What year did you earn a GED or TASC: _______

Did you play any sports in school:____

SUBSTANCE USE HISTORY

Are you a former nicotine user: Never _____ Occasionally ______ Daily _____ Weekly _____?

List the substance you abused most often (Primary): ____

How often did you abuse **primary substance**: Never _____ Occasionally ______ Daily _____ Weekly _____?

Secondary substance you abused when your primary substance **was unavailable**: _____________________________

How often did you abuse your secondary choice: Never _____ Occasionally ______ Daily _____ Weekly _____?

How often did you use Intravenous needles: Never _____ Occasionally ______ Daily _____ Weekly _____?

Approximately how old were you when **you last** used drugs or alcohol: __________________________

Approximately how old were you when **you first** used drugs or alcohol: ________________________

Approximately how old were you when **you moved out** of your parent(s) house: ______________________

Approximately how old were you when **you first dated** someone who used drugs or alcohol: ___________________

Approximately how old were **you first became pregnant** (If Applicable): _____________________________

<u>YOUR HEALTH</u>

What type of Medical Insurance do you have?: None _______ Private ________ Medicaid ________ HIP _________

If none, did you apply? _________ Date you applied: _____________________

Name of your Family Physician: ______________________________________Date of last visit: _________________

Address: ____

City: ____ State: _______________ Zip Code: ___________

List any food or medical allergies:

____

List any medical issues diagnosed by your Doctor: List your prescription medication:

____

____

____

____

<u>MAJOR SURGERIES</u>

#1. Describe Doctor's Diagnosis: ____ Year: ______________

Medication(s) Prescribed: ____

#2. Describe Doctor's Diagnosis: ____ Year: ______________

Medication(s) Prescribed: ____

Have you been admitted to a PSYCHIATRIC FACILITY: ______YES ______NO

If yes, your age?: ____________ Doctor's Diagnosis: ____

Have you been a resident in a RECOVERY HOME? _____YES _______NO

If yes, your age?: ____

For the items below, please mark an X on yes or no. If yes, print your age or ages. Ex: 12 -14

Current thoughts of self-harm Yes ____ No ____ How old were you? ____________________

History of Self-harm Yes ____ No ____ How old were you? ____________________

History of Violent Behavior Yes ____ No ____ How old were you? ____________________

Hearing Voices Yes ____ No ____ How old were you? ____________________

Recent loss of a loved one Yes ____ No ____ How old were you? ____________________

Feeling of Anxiousness Yes ____ No ____ How old were you? ____________________

Feelings of Fear Yes ____ No ____ How old were you? ____________________

History of STD/Infectious Disease Yes ____ No ____ How old were you? ____________________

History of Hepatitis Yes ____ No ____ How old were you? ____________________

History of HIV/AIDS Yes ____ No ____ How old were you? ____________________

History of Miscarriage Yes ____ No ____ How old were you? ____________________

History of Abortion Yes ____ No ____ How old were you? ____________________

History of Fainting Yes ____ No ____ How old were you? ____________________

Hospitalization Yes ____ No ____ How old were you? ____________________

Rape Yes ____ No ____ How old were you? ____________________

Domestic Violence Yes ____ No ____ How old were you? ____________________

Neglected as a Child Yes ____ No ____ How old were you? ____________________

Adopted Yes ____ No ____ How old were you? ____________________

Foster Home Placement as a Child Yes ____ No ____ How old were you? ____________________

Sexual Abuse Yes ____ No ____ How old were you? ____________________

Physical Abuse Yes ____ No ____ How old were you? ____________________

Low Self-Esteem Harm Yes ____ No ____ How old were you? ____________________

Gender Criticism/Belittlement Yes ____ No ____ How old were you? ____________________

Served in the Military Yes ____ No ____ From _____________ to _________________

Doctor Diagnosed Disabilities Yes ____ No ____ How old were you? ____________________

The information above will not exclude you from being accepted into WWRH. Your honesty helps us to create a recovery plan and reentry program that you can successfully complete.

WOR✝HY RECOVERY Inc.

MEDICATION POLICY

POLICY: It is the Policy of Worthy Women Recovery Home Inc. (WWRH) to allow ONLY vivitrol prescriptions for Medication-Assisted Treatment (MAT). Residents must discuss all medication with the WRI Executive Director. The resident must provide a signed Release of Information Form from all medical providers. The resident must bring their original signed medication policy to all medical appointments.

NOTE: Residents are strictly prohibited from obtaining any medication. Staff must verify pharmacy labels on prescribed medication containers for resident's name, physician's name, dosage, and count.

"GREEN ZONE"	"YELLOW ZONE"	"RED ZONE"
Medications ***ALLOWED*** at **WWRH**:	Medications which ***require a letter from your doctor***, to use at **WWRH**:	Medications ***NOT ALLOWED*** at **WWRH**:
Antidepressants- *Celexa, Cymbalta, Effexor, Elavil, Lexapro, Prozac, Paxil, Remeron, Savella, Zoloft* **Anti-Anxiety Medications**- *Buspar, Vistaril*	**Mood Stabilizers & Seizure Medication**- The following medications are allowed **ONLY** for documented seizure disorders: *Tegretol, Topamax, Trileptal, Lamictal*	**Benzodiazepines**- *Ativan, Klonopin, Xanax, Valium* **Antipsychotics**- Medications include, but are not limited to: *Abilify, Geodon, Latuda, Mellaril, Seroquel, Clozaril, Haldol, Risperdal, Zyprexa* **Mood stabilizers**- *Lithium, Depakote, Gabapentin*
Sleep Aids- *Trazodone and most over-the-counter sleep aids*	***Neurontin*** *may be taken by insulin-dependent diabetics as necessary for neuropathy*.	**Sleep Aids-** *Ambien, Halcion, Lunesta, Restoril, Sonata*
Non-habit forming ADD medications- *Strattera, Intuniv*	***Vivitrol**** *must be prescribed without injections.*	**ADD/ADHD Medication**- *Adderall, Concerta, Focalin, Provigil, Ritalin,* or any other "controlled" medication.
Anti-inflammatory medications such as Ibuprofen, Meloxicam, Naproxen		**Narcotic & Pain Medication**- *Codeine, Darvocet, Hydrocodone, Lortab, Lyrica, Oxycontin, Percocet, Tramadol, Ultram*
		Muscle Relaxants- *Flexeril, Robaxin, Soma, etc*.
"GREEN ZONE"	"YELLOW ZONE"	"RED ZONE"

By my signature, I affirm that I have read, understand, and agree to abide by the **WRI MEDICATION POLICY.**

Applicant Signature Print Name Date

PLEASE review your application and look for anything you might have overlooked.

By signing below, you are indicating that if accepted, you agree to follow the policies of Worthy Recovery Inc dba WWRH, and that you will **respect God, others and yourself.**

APPLICANT SIGNATURE: ______________________________ **DATE:** ______________

Mail to: WRI, PO Box 116, La Porte, IN 46352 Email: info@worthyrecovery.org Office: 219-325-3360

WRI OFFICE USE ONLY:

INTERVIEWER: ______________________________

SIGNATURE/TITLE: ______________________________ **DATE:** ______________