

Student Application



Teen Challenge

Home of Hope Women & Children's Center

PO Box 10985 | Casa Grande, Arizona 85130 | 520.836.5030 | tcazhomeofhope.org





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1. Note to the Applicant

1.1. If accepted, your commitment to Teen Challenge, Home of Hope's discipleship program will change your life. As difficult as it might be you will have to examine the underlying issues and decisions that resulted in your life controlling issues. As you submit yourself to God, participate in daily disciplines and develop positive relationships you will find yourself on the path to healing and wholeness. In time you will begin to make positive plans for the future. By the time you complete the program you will be a new person, full of potential, clean and healthy in body, soul and spirit.

2. Student Handbook

2.1.  You are required to read and understand the "Student Handbook" prior to filling out this application. This application must be filled out in its entirety, all medical tests and paper work included in order to be accepted into this program.

2.2. I certify that I have read and understand the Teen Challenge, Home of Hope program guidelines and application requirements as documented in the "Student Handbook" and the "Student Application". I agree to comply with these expectations while in the program.

Applicant Signature: _____ Date: _____

Note: Teen Challenge, Home of Hope reserves the right to accept or deny program applications.

3. Cost of Program

3.1. The cost of the Teen Challenge, Home of Hope program is defined in the Student Handbook. Teen Challenge of Arizona does not want lack of finances to keep anyone from receiving the help they need. Please discuss your financial situation with the Intake Coordinator.

3.1.1. I certify that I have read and understand the cost of the program as defined in the "Student Handbook". I fully agree to help to the best of my ability. I also agree to inform those that may contribute toward these fees of the guidelines.

Applicant Signature: _____ Date: _____

4. Personal Information

Name: _____ Phone Number: _____

Address: _____ Zip: _____

Date of Birth: _____ Age: _____ Social Security number: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color _____

Race or Ethnic Origin: _____

Marital Status: Single Married Separated Divorced

Spouse Name: _____ Phone Number: _____

Children: Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____



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5. Child Information

- 5.1. Children must be 0-6 years of age to accompany their mother into the program.
- 5.2. Fill out the requested information, one for each child. Make additional copies as needed.
- 5.3. Attach a birth certificate, immunization records and custody papers for each child.

Child's Name _____ Gender: _____
 Date of Birth: _____ Age: _____ Social Security number: _____ Grade: _____
 Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____
 Who does child currently reside with: _____ Relationship to child: _____
 Address: _____ Phone: _____
 Biological Father's Name: _____ Phone Number: _____
 Address: _____ Zip: _____
 What are the current custody arrangements? _____

Custody papers included? Yes No If no explain: _____

Is Child Protective Services (CPS) involved in the care of this child? Yes No

If yes explain: _____

CPS Case Worker: _____ Phone number: _____

Does your child have medical problems or currently receiving medical care? Yes No

Explain: _____

List any allergies: _____

Name of Physician: _____ Phone Number: _____

List Current Medications	Reason for Medication

Please provide any additional information important to the care of this child (i.e. history of abuse, trauma, behavioral problems, etc.): _____



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6. Emergency Notification

Name: _____ Phone Number: _____
Address: _____ Zip: _____
Relationship: _____

7. Health History

How would you rate your present state of health: [] Good [] Fair [] Poor
Do you have any medical problems? _____

List any allergies: _____

Name of Physician: _____ Phone Number: _____

Are you currently receiving medical care? [] Yes [] No

Table with 2 columns: List Current Medications, Reason for Medication

Did you have these childhood immunizations? [] Polio [] Mumps [] Measles
[] Chicken Pox [] Rubella [] Other _____ Date of last Tetanus shot: _____

Are you now or have you ever been treated for mental illness? [] Yes [] No

Explain: _____

Name of Doctor: _____ Phone Number: _____

Please list all medications prescribed for mental illness or chemical imbalance and length of use:

Table with 3 columns: Medication, Period of use, Are you willing to try alternative treatments under a doctor's care?

Have you been diagnosed with any of the following:

- [] Head, Spinal or Other Serious Injury [] Seizures, Convulsions or Fainting
[] Extensive Confinement by Illness/Injury [] Cardiovascular Disease
[] Tuberculosis [] Syphilis or Gonorrhea or Other V.D.
[] Diabetes [] Asthma
[] Cancer or Tumor [] Gastrointestinal Ulcer
[] Rheumatic Fever [] Nervous Stomach
[] Muscular Disease [] Psychiatric Disorder
[] Any Other Nervous Disorder [] Other:
[] Permanent Defect From Illness, Disease or Injury



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If yes, explain: _____

8. Interest in Recovery

Referred by: _____

How do you rate your need to enter the Teen Challenge program?

- Emergency Whenever there is an opening I do not need the program

Do you believe you have a serious problem? Yes No

Explain: _____

What do you hope to get out of this program? _____

Check all the reasons that best describe why you want to enter this program:

- | | |
|---|--|
| <input type="checkbox"/> I want to be free from alcohol/drugs | <input type="checkbox"/> I want to become a Christian |
| <input type="checkbox"/> My probation officer is forcing me | <input type="checkbox"/> I want to improve my health |
| <input type="checkbox"/> I need discipline in my life | <input type="checkbox"/> I am trying to avoid arrest/violation |
| <input type="checkbox"/> I want to provide for my kids | <input type="checkbox"/> I want to start a new life |
| <input type="checkbox"/> I just need housing | <input type="checkbox"/> I need help in many areas |
| <input type="checkbox"/> My family is forcing me | <input type="checkbox"/> I want to be a good mom |

Check the information that describes your drug history. Identify the severity and if currently using:

Drug	Severity	Currently using	Drug	Severity	Currently using
<input type="checkbox"/> Alcohol	1 -----5----- 10	<input type="checkbox"/> Yes	<input type="checkbox"/> Amphetamines	1 -----5----- 10	<input type="checkbox"/> Yes
<input type="checkbox"/> Marijuana	1 -----5----- 10	<input type="checkbox"/> Yes	<input type="checkbox"/> Heroin/Opiates	1 -----5----- 10	<input type="checkbox"/> Yes
<input type="checkbox"/> Glue/Paint	1 -----5----- 10	<input type="checkbox"/> Yes	<input type="checkbox"/> Hallucinogens	1 -----5----- 10	<input type="checkbox"/> Yes
<input type="checkbox"/> Cocaine	1 -----5----- 10	<input type="checkbox"/> Yes	<input type="checkbox"/> Barbiturates	1 -----5----- 10	<input type="checkbox"/> Yes
<input type="checkbox"/> Inhalants	1 -----5----- 10	<input type="checkbox"/> Yes	<input type="checkbox"/> Bath salts	1 -----5----- 10	<input type="checkbox"/> Yes
<input type="checkbox"/> Crystal	1 -----5----- 10	<input type="checkbox"/> Yes	<input type="checkbox"/> _____	1 -----5----- 10	<input type="checkbox"/> Yes
<input type="checkbox"/> _____	1 -----5----- 10	<input type="checkbox"/> Yes	<input type="checkbox"/> _____	1 -----5----- 10	<input type="checkbox"/> Yes



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9. Additional Information

Check all the statements that are currently true to your life:

- I have a problem with violence
I am confused about my sexual orientation
I am suicidal
I hate myself
I yell at my kid
I was sexually abused as a child
I sometimes or frequently cut/hurt myself
I want to become sexually pure
I want to change my life at any cost
I consider myself to be homosexual
I love my family
I lose control when I am angry
I don't think it's wrong that I'm a lesbian
I am proud of my sexual activity
I am ashamed of my lifestyle
I have been arrested for sexual actions
I don't need help with my problems
I need help raising my kids

Have you ever been convicted of a sex offense? Yes No

If yes, explain:

Are you registered in any state as a sex offender? Yes No

Degree: 1 2 3 If yes, explain:

Have you been in a Teen Challenge program before? Yes No

If yes, explain:

Have you ever committed your life to Jesus?

Were you raised in church? Yes No Church Name:

Have you ever been involved with a cult? Yes No If yes, explain:

Did program applicant complete this application personally? Yes No

Explain:

10. Legal Status

Charges pending? Yes No Nature of Charges:

Probation/Parole Officer: Phone Number:

Public Defender/Attorney: Phone Number:

10.1. I have disclosed all my pending legal issues.

Applicant Signature: Date:



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11. Authorization for Use or Disclosure of Protection of Health Information

Name: _____ DOB: _____ SSN: _____

11.1. I authorize Teen Challenge of Arizona to disclose to the following individuals:

Name: _____ Phone Number: _____

Address: _____ Zip: _____

Type of Information Given: _____

Name: _____ Phone Number: _____

Address: _____ Zip: _____

Type of Information Given: _____

Name: _____ Phone Number: _____

Address: _____ Zip: _____

Type of Information Given: _____

Name: _____ Phone Number: _____

Address: _____ Zip: _____

Type of Information Given: _____

11.2. The information disclosed is from records protected by Federal Confidentiality Rules (42CFR, part 2) and state regulations (Arizona Administrative Code R9-20-201, and Arizona Revised Statute 12-2294(F) and 36-664) The federal and state rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by the patient's written consent, or as otherwise permitted by state and federal regulations. A general authorization for release of medical or other information is NOT sufficient consent for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

11.3. A photocopy of this consent is as valid as the original.

Applicant Signature: _____ Date: _____

Staff Signature: _____ Date: _____

12. Revocation of Consent (complete only to revoke above consent of protected health information)

I _____, Hereby revoke or cancel this consent effective date _____

Applicant Signature: _____ Date: _____

12.1. Per Federal Regulations: No disclosure may be made on a form, which does not conform to federal regulations and contain the above data. Further, if document appears false or altered, information will not be disclosed.



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13. Release of All Rights in Personal Story

- 13.1. In consideration of and as a condition to my admission to Teen Challenge of Arizona, Home of Hope Christian recovery and discipleship program, I hereby give Teen Challenge of Arizona, Home of Hope and its sub-licensees, assigns and legal representatives including, but not limited to Teen Challenge USA and Global Teen Challenge the perpetual, unlimited, but revocable worldwide right to use, publish and/or broadcast my name and personal story which I have related to Teen Challenge of Arizona, Home of Hope in whole, or in part, along with my voice, name, statements, testimonials, pictures, photographs and/or composite representations thereof for archival, educational, inspirational, advertising, publicity, promotion, news, documentary, print, broadcast, and in all electronic and other media. This grant includes the right to modify and edit any film, videotape, audiotape and photograph taken or made of me during my participation in the program, and to use words, symbols, designs, illustrations, recordings or other communications elements in conjunction with it or them.
- 13.2. The Licensee will not use any information about me other than what I voluntarily and personally provide.
- 13.3. I agree that all recordings, video, film, photography, drawings or other images taken or made of me or my children by the Licensee are owned by it and that it may copyright any such creative works. If I should receive any print, negative or other copy thereof, I shall not authorize its use by anyone else. I hereby waive my right to review or approve any of the above or the use to which they may be applied. The Licensee shall not be obligated to make use of any of the rights granted therein.
- 13.4. I hereby release, discharge and agree to hold the Licensee, its sub-licensees and all persons acting with its permission or authority harmless from any claim, demand or liability attributable to any use or activity authorized herein, including without limitation any claims for defamation, libel or invasion of privacy or publicity rights.
- 13.5. I have read the above and I fully understand and agree to the contents thereof. This agreement shall be binding upon me and my survivors, heirs, legal representatives and assigns.
- 13.6. I understand that upon ninety days written notice from me to Teen Challenge of Arizona, Home of Hope, the Program will discontinue all uses and activities authorized above, and, if it has authorized third parties to make such uses or engage in such activities, it will make reasonable efforts to see that such third party or parties discontinues them as well.

Applicant Signature: _____ Date: _____
 Staff Signature: _____ Date: _____



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14. Cold Turkey Policy

14.1. Teen Challenge's method of drug, alcohol, and tobacco withdrawal is totally and absolutely without substitute medications. Our "cold turkey" policy must be agreed upon for acceptance into the program. Applicants must indicate their need for medical detoxification. Periodic urine drug testing will be made to check for drugs, including nicotine.

Applicant Signature: _____ Date: _____
Staff Signature: _____ Date: _____

15. Sexual/Moral Standard

15.1. Teen Challenge, Home of Hope upholds Christian, biblically based moral standards. In our teaching and in practice observed by staff and students, all forms of sexual activity outside of marriage between a husband and a wife are inappropriate and outside the boundaries of what God has ordained. Therefore adultery, extra marital sex, either heterosexual or homosexual, will not be allowed while in the Teen Challenge program. I have read this and agree to abide by this policy while I am at Teen Challenge.

Applicant Signature: _____ Date: _____
Staff Signature: _____ Date: _____

16. Official Aids Policy

16.1. Teen Challenge does not discriminate against those who are HIV positive in its admission procedures. Because a large number of IV drug users have been exposed to the HIV virus at any time there may be one or more students in the program who are HIV positive. This center does not require students who are HIV positive to notify other students in the program of their HIV status.

16.2. Teen Challenge is not a medical care facility and is unable to provide 24-hour on-site medical care supervision. Therefore, all students entering the program must be in good health and be able to participate in all activities in the program. If a student's health deteriorates to the point where he/she is no longer able to participate in daily activities of the program, or medical condition requires 24 hour supervision, that person should leave the Teen Challenge program after securing alternative living arrangements.

Applicant Signature: _____ Date: _____
Staff Signature: _____ Date: _____

17. Student Rights

- 17.1. The right to give informed consent, or to refuse treatment or medication, and to be advised of the consequences of such a decision.
- 17.2. The right to a grievance procedure.



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- 17.3. The right to a humane and safe environment, free from abuse, neglect, and exploitation.
- 17.4. The right to dignity and personal privacy.
- 17.5. The right to know about the cost and third-party coverage of treatment, including any limitations on the duration of treatment.
- 17.6. The right to receive a complete explanation of student rights in clear, non-technical terms in a language the student understands.
- 17.7. The right not to be detained against the legal consenters' will.
- 17.8. The right to medical or psychological/psychiatric care either through referral or direct service delivery.
- 17.9. The right to be informed of the financial responsibility for these services.

Applicant Signature: _____

Date: _____

Staff Signature: _____

Date: _____

18. Student Acknowledgement Regarding Work Assignments

- 18.1. I understand that if I am admitted as a student, that I will be required to participate in Teen Challenge Work Therapy Program.
- 18.2. I acknowledge that I have read and fully agree with Teen Challenge programs description of its work Therapy Program, which addresses the importance of my work assignments in helping to build in me the biblical values of a good work ethic and the character of a responsible, upright individual.
- 18.3. I understand that if I am admitted, I will be performing my work assignments not as an employee of Teen Challenge, but solely for my benefit, to further my spiritual growth, maturity, character development, recovery, and readiness to go back into the work place.
- 18.4. Accordingly, by submitting this application, I am not applying for a position of employment, and if admitted, I understand I will not be receiving any compensation or in-kind benefits in exchange for the performance of any work assignments.
- 18.5. I further understand that if I fail to perform my work assignments, Teen Challenge may revoke my status and privileges as student, not because performance of work assignments are the consideration for the receipt of such status and benefits, but because each student participation in the work therapy program is a necessary and vital part of the recovery process.

Applicant Signature: _____

Date: _____

Staff Signature: _____

Date: _____



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19. Confidentiality of Teen Challenge Records - *In accordance with 42 CFR part 2.1 (10/1/91 Ed.)*

- 19.1. The confidentiality of alcohol and drug abuse patient records maintained by this ministry is protected by federal law and regulations. Federally, the ministry may not say to a person outside the program that a student attends the program, or disclose any information identifying a student with a life controlling problem, especially alcohol, or drug abuse unless:
 - 19.1.1. The student consents in writing.
 - 19.1.2. The disclosure is allowed by a court order.
 - 19.1.3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
- 19.2. Violation of the federal law and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations. Federal law and regulations do not protect any information about a crime committed by a student either at the program or against any person who works for the program or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.
- 19.3. I warrant that I have read the above notice prior to its execution, and that I am fully familiar with the contents thereof.

Applicant Signature: _____

Date: _____

Staff Signature: _____

Date: _____

20. Release of Responsibility

- 20.1. I understand that Teen Challenge will not be held responsible for any personal property left, lost or stolen, while in the program. When leaving the program, I will take all personal property with me.
- 20.2. I release the right to Teen Challenge to search my belongings and my person.
- 20.3. I understand that if an application fee was paid by me or on my behalf, it is not refundable and that intake fees are refundable under terms outlined in the student application.
- 20.4. I will submit to periodical blood or urinalysis drug screening while in the program.
- 20.5. I release Teen Challenge from all responsibility, both physical and financial, in the case of accident, injury, illness, or other imponderable misfortune.
- 20.6. I give Teen Challenge permission to open and check both incoming and outgoing mail for anything that might be harmful to the welfare of the program residents. I understand that all phone calls made by me or received for me will be screened and/or monitored.
- 20.7. I understand that I must provide a medical examination including laboratory tests for admittance into the program.



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20.8. I understand that Teen Challenge of Arizona, Inc. is a ministry to those with life-controlling problems, including drug dependency. Applicants are advised that many persons enrolled in the program have been involved in high-risk behavior, which may have exposed them to the AIDS virus in the past. I have been advised that there is a possibility that some of those enrolled in the program could be HIV positive.

Applicant Signature:

Date:

Staff Signature: _____

Date: _____

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21. Confidential Release

21.1. I, _____, hereby grant a full release of medical information to Teen Challenge and its agents. I further grant Teen Challenge or its agents the right to have conferences, including telephone conferences, with your agency or affiliates for purposes of discussing said information for purposes of effecting satisfaction of the needs and purposes of Teen Challenge.

Applicant Signature:

Date:

Staff Signature: _____

22. Medical Authorization Release

22.1. I, _____, hereby authorize Teen Challenge of Arizona to make arrangements for any emergency medical assistance that may be required due to illness or injury on my behalf.

Applicant Signature:

Date:

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23. Limited Power of Attorney

- 23.1. I, _____, a resident of _____ county, Arizona, hereby make, constitute, and appoint Teen Challenge of Arizona, Inc., an Arizona corporation, my true and lawful attorney-in-fact for me, and in my name, and for my use and benefits to execute, and negotiate, and endorse any and all checks, warrants, or other instruments payable to me from any third-party, entity, the State of Arizona or the Department of Economic Security or Social Security Administration for a period of one (1) year from the date of this instrument or as long as benefits last while in the Teen Challenge program.
- 23.2. This power of attorney shall not be affected by the disability of the principal and shall remain in full force and effect for a period of one (1) year or as long as benefits last while in the Teen Challenge program.
- 23.3. In witness, whereof, the said principal has hereunto set his/her hand (or willingly directed another to sign for him/her) this _____ day of _____, _____.
- 23.4. This power of attorney shall not be affected by the disability of the principal and shall remain in full force and effect for a period of one (1) year or as long as benefits last while in the Teen Challenge program.
- 23.5. In witness, whereof, the said principal has hereunto set his/her hand (or willingly directed another to sign for him/her) this _____ day of _____, _____.

State of Arizona)
) SS.
 County of _____)

On this _____ day of _____, _____, before me, the undersign notary public, personally appeared _____, known to me to be the person whose name is subscribed to the foregoing power of attorney and acknowledged that he/she executed the same for the purpose therein expressed. In wittnessof, I have hereunto set my hand and official seal.

Notary Public Signature _____ Commission expiration _____

- 23.6. The notary public signature and seal will also serve as verification that the program applicant has read and understands and in signing agrees to cooperate with "section 7 - policies" in its entirety as well as all of the Teen Challenge general rules and policies outlined in the student application.

Applicant Signature: _____ Date: _____



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24. Physical and Health Examination

24.1. This form must be completed by a Medical Doctor, Physician's Assistant or Nurse Practitioner and signed at the bottom.

Name: _____ Date of Birth: _____

Present illness/complaint/disabilities, if any: _____

Allergies: _____

Medication currently prescribed and reasons for use: _____

Has client been exposed to any communicable disease? Yes No

If "yes" specify: _____

Past History of chronic or major illness: _____

Operations: _____

Hospitalizations: _____

Respirations: _____

24.2. General Appearance and Development (include signs of drug abuse)

Skin: _____

Nutrition: _____

Head: _____

Ears L____ R____	Hearing L____ R____	Eyes L____ R____	Vision w/o glasses L____ R____	Vision w/glasses L____ R____
Nose	Neck/Thyroid	Throat	Mouth/Teeth	Cardiac
Abdomen	Breast	Genitalia	Hernia	Muscular/Skeletal

24.3. Required Lab Work

Hepatitis Panel: _____

V.D.R.L: _____ Urinalysis: _____

Pregnancy: _____ HIV _____

TB: _____ Chest X-Ray (if T.B. positive): _____

Doctors Name: _____ Doctors Signature: _____

Address: _____ Phone Number: _____ Exam Date: _____

Applicants Physical and Health Examination: Pass Fail