



Changed Lives Ministry (Men's)

Student Application (Please neatly print all requested information.)

Full Name _____ Date _____

Name you like to be called _____

Address _____

City _____ State _____ Zip _____

Phone (____) _____ Additional Contact Number (____) _____

Date of Birth ____/____/____ (month/day/year) Age _____ Height _____ Weight _____

Can you read well? not well _____

Social Security Number _____/_____/_____

Valid Driver's License Number _____ State _____

Single _____ Married _____ Separated _____ Widowed _____ Divorced _____ Engaged _____

If Married, Spouse's Name _____

Children? _____ Names and Ages _____

Emergency Contact _____ Phone (____) _____

Addiction and Medical Issues

List the substances to which you're addicted:

List other medications you are currently taking:

List all medical conditions (bi-polar, handicapped, schizophrenia, etc.):

Have you ever had convulsions, seizures, or blackouts? Yes _____ No _____

List any allergies _____

Do you have heart disease, diabetes, epilepsy, respiratory disease, etc.? Yes _____ No _____

Do you have a Naltrexone Implant? Yes _____ No _____

Do you have a doctor? Yes ___ No ___ Name/Number _____

Do you have medical insurance? Yes ___ No ___

Insurance Company _____

Phone (_____) _____ Fax(_____) _____

Policy Number _____

Sign here to give permission to Changed Lives Ministry to consult with your doctor, insurance company, or health department about your medical situation:

Sign: _____ Date _____

Legal Issues

List all pending court dates, jail terms, Charges, etc.:

Are you ordered by the court to enroll in this program? _____

Are you under bond? _____ County/State _____

Do you have a Probation Officer? ___ Name/Number _____

Do you have an Attorney? _____ Name/Number _____

Sign here to authorize Changed Lives Ministry to a background check, consult with your Probation Officer and/or your attorney regarding your legal situations:

Sign your name _____ Date _____

For Office Use Only

Probation Officer Consulted? _____ Date: _____/_____/_____

Probation Officer's Name/Number _____

Notes: _____

Attorney Consulted? _____ Date: _____/_____/_____

Attorney's Name/Number _____

Notes: _____

Manager/Director Signature: _____ Date _____

Student's Name _____

Changed Lives Ministry

Sponsor's Responsibilities

1. Assuring the resident has the necessary blood tests faxed to us.
2. Assuring the resident has transportation to and from CLM facility. If a situation arises that a resident cannot or does not desire to complete the program, the sponsor is responsible for picking that individual up **promptly upon departure**.
3. Assuring the three hundred and twenty-five dollar (\$325) medical deposit upon entrance. This is for the resident's use should they require medical assistance while in the program. **A non-refundable processing fee of \$25 will be deducted.** At no time during the resident's stay is the medical deposit to be used for anything other than medical expenses.
4. Assuring no alcohol or drugs are in the resident's belongings upon arrival.
5. Assuring that the resident has all needed items such as clothing, toiletries, etc. (No toiletries, cosmetics, etc. containing alcohol content are allowed.)
6. Assuring that the resident brings any proper/necessary prescription medications needed for the duration of time in the program.
7. The resident will be drug/alcohol tested upon arrival. A positive test result will terminate any current admissions agreement and the resident will not be permitted to remain at the CLM facility at that time. Should this occur, it is the responsibility of the sponsor to provide transportation from the CLM facility. The resident may be rescheduled to come in at a later date.

SPONSORS AGREEMENT:

"I take responsibility for all of the above as this resident's sponsor".

Residents Name: _____.

Sponsors Name: _____.

Address: _____.

Telephone Number: _____.

Signature: _____ Date: _____.



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Pre-Admission Blood Test Report

This form is to be submitted to your health care provider (doctor, clinic or Health Department), then faxed directly to Changed Lives Ministry by your provider.

_____ has applied for entrance into Changed Lives Ministry for a ten-week drug and alcohol rehabilitation program.

Blood Tests for the following are required for admissions into our program:

TEST RESULTS/COMMENTS/RECOMMENDATIONS

HIV

STD/RPR

PPD

HEPATITIS C

Flu Shot

Please complete in full, then fax directly, with your agency's cover sheet, to Changed Lives Ministry @ FAX (843) 899-2193

Thank you,

Keith Griggs, Director
CHANGED LIVES MINISTRY
470 Reid Hill Road
Monck's Corner S.C. 29461
Phone: (843) 899-4014
FAX: (843) 899-2193