Serenity Living, LLC Resident Application

Serenity Living, LLC is a Christ-centered, sober living home. We accept women, and women hoping to reestablish relationships with their non-custodial children. Serenity Living, LLC is a NON-SMOKING facility.

Instructions: All applicants are required to personally complete the application in its entirety by herself. Any questions must be answered thoroughly and accurately to be processed.

Name_____ Date_____

Maiden Name or Aliases_____ SSN_____

How did you hear about us?_____

Have you ever applied with us before? Yes/No If yes, when?_____

Phone_____ Date of Birth_____ Age_____ Race_____

Current Address_____ Length of Residency_____

Please check the box below that best describes your current living situation:

- ☐ Homeless
- ☐ Mother transient (Children with relatives/friends
- ☐ Domestic Violence situation
- ☐ Emergency Shelter
- ☐ Transitional Housing
- ☐ Psychiatric Facility
- ☐ Substance Abuse Treatment Facility
- ☐ Hospital
- ☐ Jail/Prison
- ☐ Rental Housing
- ☐ Own Home
- ☐ Other:_____

If you are currently residing in a jail or prison, please provide the following information.

Name of Facility_____

Representative's Name & Contact Info_____

Date of Admission_____ Anticipated Release Date_____

Previous Address_____ Length of Residency_____

Please list the name and contact info for 2 individuals we may contact if we are unable to reach you.

Name_____ Phone_____

Name_____ Phone_____

IDENTIFICATION – Circle "Yes" or "No" to indicate if you have a copy of the following:

Birth Certificate: Yes/No Driver's License or State ID: Yes/No Social Security Card: Yes/No

Name_____

RELIGION – Serenity Living is a Christ centered, faith based home and participation in devotionals, Bible study, home church, etc. is required during your stay.

Please list any and all religious/spiritual organizations you have been affiliated with, both past and present:_____

Where do you see yourself spiritually?_____

_____

Have you ever been exposed, or participated in, witchcraft or satanic ritual abuse activities?
Yes / No
If yes, please explain_____

MEDICAL HISTORY

Please provide the information below for all medications you are currently taking or prescribed.

Medication	Reason for taking	Dosage	Times per day	Date prescribed

Please provide below all medications you have taken during the past 6 months.

Medication	Reason for taking	Dosage	Times per day	Date prescribed

Please check "Yes" or "No" to indicate if you have ever been diagnosed with or experienced the following:

	Yes	No		Yes	No
Hepatitis A			Tuberculosis (TB)		
Hepatitis B			HIV/AIDS		
Hepatitis C			Physical Disability		

Please list all allergies:_____

Are you currently pregnant? Yes/No If yes, how many weeks?_____ Due Date:_____

Have you ever had an abortion? Yes/No

Please check "Yes" or "No" below in which you are able to perform the following actions:

Housework	Yes	No	Yard Work	Yes	No	Farm Work	Yes	No
Cooking			Mowing			Tend to pigs		
Dusting			Weeding			Tend to chickens		
Laundry			Trimming			Tend to cats		
Mopping			Landscaping			Lift 50# bags		
Vacuuming			Gardening					

If you are unable to perform any of the items above, please indicate the reason why:_____

_____

MENTAL HEALTH HISTORY

Please check "Yes" or "No" to indicate if you have ever been diagnosed with any of the following:

	Yes	No		Yes	No		Yes	No
Anxiety			Antisocial Personality Disorder			OCD		
Bipolar			Borderline Personality Disorder			PTSD		
Depression			Multiple Personality Disorder			Schizophrenia		

List any other mental health diagnoses not listed above_____
Please check "Yes" or "No" to indicate the mental health services you have received in the past.

	Yes	No		Yes	No		Yes	No
Case Management			Medication Management			In-patient Treatment		
Counseling			Mental Health Court			Out-patient Treatment		
Hospitalization			Mobile Crisis					

If yes, please list the facility name, contact information, and dates of treatment_____

_____

Have you ever had thoughts of hurting yourself and/or others? Yes / No
If yes, when was the last time you experienced these thoughts?_____

Does anyone in your family have a history of mental health illness? Yes / No

If yes, please indicate the mental health illness and the family member diagnosed_____

_____

INSURANCE INFORMATION

Behavioral Health Insurance: _____ Policy Number:_____

Dental Insurance:_____ Policy Number:_____

Health Insurance:_____ Policy Number:_____

SUBSTANCE ABUSE

Tobacco Use

Do you currently smoke tobacco or nicotine products? Yes / No If yes, for how long?_____

Have you ever tried to quit? Yes / No If yes, how long were you successful?_____

If you currently smoke, please describe how you feel about quitting._____

_____

Alcohol Use

Have you ever used alcohol? Yes / No If yes, how long?_____ Age of first drink:_____

Have you ever tried to quit? Yes / No If yes, how many times?_____

Please provide the names of your most recent treatment facility:_____

Did you complete the treatment? Yes / No If no, why not?_____

Does anyone in your family have a history of alcohol abuse? Yes / No

Drug Use

Have you ever abused drugs? Yes / No Do you feel you are addicted to drugs? Yes / No

Please provide the information below for all drugs you have used.

Drug	Method of administration	Age of 1st use	Frequency of use	Quantity used	Date of last use	Longest period of sobriety

Have you ever been in a drug treatment or recovery program? Yes / No

If yes, how many times?_____

Please provide the name of your most recent treatment facility:_____

Did you complete the treatment? Yes / No If no, why not?_____

_____

Does anyone in your family have a history of drug abuse? Yes / No

VIOLENCE / ABUSE HISTORY

Please circle "Yes" or "No" to indicate if you have experienced the following as an adult or child.

	As a Child	As an Adult
Have you ever been a victim of domestic violence?		
Have you ever been perpetrator of domestic violence?		
Have you ever been a victim of sexual assault, rape, or incest?		
Have you ever been perpetrator of sexual assault, rape, or incest?		

Does anyone in your family have a history of domestic violence? Yes / No

LEGAL HISTORY

Are you currently on probation or parole? Yes / No If yes, for what charges?_____

_____

Please list the information below for all correction, probation, and parole officers.

Officer's Name	Probation Office	Phone Number

Have you ever been convicted of a felony? Yes / No Do you have pending charges? Yes / No

Please list the 5 most recent convictions/charges:

Date	County	Charge	Outcome / Sentencing

EDUCATION HISTORY

Do you have a GED? Yes / No If no, are you interested in obtaining your GED? Yes / No

What is the highest grade completed?_____ What are you educational goals and interests?

_____

_____

EMPLOYMENT BACKGROUND / INCOME

Complete the information below for your last 3 employers. Please list the most current first.

Employment Dates	Employer Name, Address, Phone	Job Title	Primary Responsibilities	Wage / Salary	Reason for Leaving
From: To:					
From: To:					
From: To:					
From: To:					

Please check “Yes” or “No” to indicate if you receive the following benefits. If yes, please also list the amount.

Program	**Yes**	**No**	**Amount per Month**
WIC			
SNAP			
Families 1st			
Supplemental Security Income (SSI)			
Child Support			
Other			

Checking Account: Yes / No Debit Card: Yes / No Savings Account: Yes / No

RELATIONSHIP BACKGROUND – please circle one

Marital Status: Single / Dating / Married / Separated / Divorced / Widowed

How do you feel about giving up romantic relationships for the duration of your recovery program?_____

_____

_____

PERSONAL NARRATIVES

My personal goal and dream for myself is:

How do you feel about a 1-2 year commitment?

How do you feel about living in a community setting?

How do you see our program enabling you to become self-sufficient?

How do you feel about the necessary rules and restrictions as a resident?

How do you feel about not having a cell phone and personal calls being limited to four calls per week?

What are your expectations of Serenity Living?

What are your concerns about Serenity Living?

Why should we consider you for residency here at Serenity Living?

How do you feel you would benefit from being involved in our program?

Authorization of Release of Information

Name:_____ DOB:_____

Address:_____

SSN:_____-_____-_____

I hereby authorize the release of the following information:

Yes	No	
_____	_____	1. Medical history, examination, laboratory test, and treatment reports
_____	_____	2. Psychological test reports
_____	_____	3. Psychiatric evaluation reports
_____	_____	4. Social history data, including family, education, employment, and other relevant material
_____	_____	5. Summary of previous mental health treatment
_____	_____	6. Periodic reports of treatment progress, including attendance and participation.
_____	_____	7. Other, please specify:_____

Persons / facilities authorized to make disclosure:

1. _____
2. _____
3. _____
4. _____

Persons / facility authorized to receive the disclosure:

145 McCullough Lane
Wartrace, TN 37183

I understand no information may be disclosed by an agency to another agency or individual without my written consent. This authorization may be any time by my written statement, and it is automatically revoked at the end of treatment unless otherwise specified.

This consent for the release of information is given freely, voluntarily, and without coercion.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

Applicant's Certification and Agreement

I, _____, personally completed this application without assistance or input from others. I confirm all information to be true and accurate. I authorize Serenity Living to use the information I provided to make a decision regarding my acceptance into this program.

_____ _____
Applicant's Signature Date of Completion

I, _____, understand that if I am accepted, I agree to follow all program guidelines. Upon admission, I agree to sign the resident handbook containing behavioral agreements, policies, and procedures as well as an updated release of information.

_____ _____
Applicant's Signature Date

I, _____, understand that alcohol, drugs, and nicotine testing will be conducted prior to admission and consistently during residency. I agree to complete these screenings upon request and understand that testing positive for alcohol, drugs, or nicotine could result in discharge from the program.

_____ _____
Applicant's Signature Date

APPLICATION & ADMISSION PROCESS

Once your application is received, you will be contacted via phone. During this conversation all information will be verified whether or not you meet our program requirements and if Serenity Living is a good fit for your needs. If approved, you will contacted for in person interview at the home. If the home is full you will be placed on a waiting list, and when an opening becomes available. Pending applications will be contacted based on the date their application was received. Applicant must be able to pass an alcohol and drug screen prior to admission. Please, if you have further questions, please do not hesitate to reach out to Serenity Living. Thank you for your interest in our pgoram and we look forward to working with you!

Return application to:
145 McCullough Lane Wartrace, TN 37183
Phone: 931-570-1360 / Email: info@serenityliving145.com