CHANCE HOUSE OF EAST TENNESSEE

RECOVERY LIVING FOR WOMEN

Reentry Program Application

7/24/2019

For CHET Staff Use Only

Application Rec'd _____

Name: _____ Date: _____ Current Location: _____

Each Question & Section of this application must be complete to be considered for approval.

Applicant Qualifications for the Re-Entry Programs: (Check All That Apply)

- o A woman 18 years of age or older
- o Currently incarcerated in a county or state correctional facility
- o Has an addiction to substance
- o Willingly /able to work up to 40 hours per week in order to pay weekly program fee ($124)
- o Willing to volunteer
- o Client must be ambulatory and able to do activities of daily living such as: dressing, bathing, feeding)

Is this your first time applying for transitional housing at Chance House of East Tennessee? Yes Or No

* CHET do not accept returning applicants *

PERSONAL INFORMATION (PROVIDE JAIL/PRISON ADDRESS)

Name _____ Social Security # _____

TDOC/Inmate # _____ Date of Birth _____ Age _____ Martial Status _____

Present Address (Jail/Prison) _____ How long? _____

City _____ State _____ Zip _____ Phone _____

MEDICAL HISTORY

Chance House of East Tennessee, does not discriminate based on medical history or diagnosis. CHET reserved the right to accept/decline application for our program. Any information provided will be protected and will not be shared with individuals without written consent by the applicant.

*** Please mark the following yes or no questions with an X. ***

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Please Provide A List of the Medications you are currently taking: (Write N/A of not Applicable)

Medication	Reason for Taking	Dosage	Time Per Day	Date Prescribed

- **Staff will be responsible for administering all residents all non/prescription meds ***

Do you any allergies? Yes___ No___ If yes, explain _____

_____

Do you have any chronic medical conditions (i.e. high blood pressure, diabetes, thyroid, et.)?

_____

Have you ever been told you needed surgery for any medical condition? _____

If so, when _____

What was it for? _____

Are you pregnant? Yes___ No___ * CHET cannot approve applicants who are pregnant.

Do you owe child support? Yes____ No____

If yes, what amount do you owe? _____ Monthly Payments Amount: _____

Have your wages been garnished due to child support? Yes____ No____

MENTAL HEALTH HISTORY

Have you ever been or are currently diagnosed with mental health illness? Yes____ No____

If yes, what is your historical or current mental health diagnosis? _____

Have you ever attempted suicide or tried to kill someone else? _____

If yes, please describe when and how you though or attempted in the past. _____

_____

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SUBSTANCE USE/ABUSE HISTORY

Alcohol Use

What age did you start drinking? _____ How have you been drinking? _____

When was your last drink?_____

Do you feel you are addicted to alcohol? Yes___ No___

Have you tried to stop using alcohol in the past? Yes___ No___

Have you ever been in treatment? Yes____ No___

If yes, when, and where _____

What were the consequences of your use? _____

Drug Use

What was /is your drug (s) of choice? _____

What age did you start using drugs? _____ How long did/have you used? _____

How often would you use? _____ When did you last use? _____

Do you feel you are addicted to drugs? Yes___ No___

Have you tried to stop before? Yes___ No___

Have you ever been in treatment or recovery programs? Yes___ No___

If yes, when? _____

If Yes, where? _____

What were the consequences of your use? _____

Are you willing to work CHET intensive recovery program? _____

LEGAL ISSUES

Are you or will you be on Parole or Probation upon release? Yes___ No___

Incarceration History: What are your current charges? _____

_____

Do you have any pending charges or outstanding warrants in any other counties/states? Yes___ No___

Have you ever been convicted of a sex offense? Yes___ No___

Have you ever received a write-up(s) Yes___ No___ How many? _____

If yes, please identify the write-up (s) and explain? _____

_____

When was your most recent write-up? _____

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COLLATERAL CONTACT INFORMATION

In order for us to facilitate your possible admittance into our program, we must have a way to obtain information regarding your release. Please provide the name and phone number of a corrections/re-entry counselors who we may contact.

Name: _____Phone Number _____

Position (Case Manager/counselor/Sgt./etc.): _____

EMPLOYMENT BACKGROUND

All residents **must** find employment and maintain at least 30-40 hours per week.

Do you feel that you are capable of working at least 30-40 hours per week? Yes____ No____

Last Year Employed: _____

EMERGENCY CONTACT INFORMATION

If I am approved for residency, I give Chance House of East TN permission to contact the following individual in the event of an emergency and to assist in arranging transportation CHET:

Name _____ Relationship _____

Telephone Number (Including Area Code)_____

Address _____

I agree that the information provided is true and accurate to my knowledge. I give CHET permission to use the information given to make a decision regarding my acceptance into the program or to help with my admission date and/or transportation. I further understand that if I am approved, I will be expected to be compliant with the program guidelines.

Sign _____ Date _____

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Out of the following issues, what are your priorities upon release? Please circle 3-5.

- Housing
- Employment
- Food Education
- Health Care/Medical needs
- Life Skills
- Family/Social Relationships
- Mental
- Health

Substance Abuse/Recovery

Safety

Other: _____

Other:_____

Why are you willing to commit for up to 6 month program? _____

_____

_____

_____

_____

RELEASES OF INFORMATION

To facilitate your journey through the admissions process, you are required to complete the **Release of Information** included on the next page. This form means you are giving the facility you are located in permission to talk to CHET and help schedule possible admissions to the program. **You must complete and return this form in order for your application to be processed.**

1. Please fill in your name, date of birth, social security number at the top of the page.
2. Then fill in the name and address of the facility you are currently located in.
3. Write the date you entered incarceration in the space next to Treatment dates to release: From:
4. Next to the words Treatment dates to release: To: Please date it 6 months from the date
5. Please sign and date at the bottom of the page.

If you have outside individuals or parties (attorneys, public defenders, family member, etc.) whom we need to discuss your case with, an additional general release of information form is included on page 6. If an applicant refuses to sign a release of information for any party, CHET will not be able to confirm or deny information pertaining to that applicant due to Federal Laws of Confidentially.

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Authorization for Release of Information

(Criminal Justice Referrals)

NAME _____ DOB _____ SOCIAL SECURITY# _____

I hereby authorize the release of the following specific information: (check all item that apply)

Presence in Treatment	Aftercare Plans	Progress in Treatment
Medication Record	Psychiatric Evaluation	Psychosocial History
Admissions and Discharge Dates	Diagnosis	Discharge Summary
Physicians H & P	Labs & Ancillary Labs	HIV– Related Information
Complete Client File (excluding Psycho-therapy notes	Discharge Certificate	

OTHER Specify _____

Psychotherapy Notes:

_____

NOTE: If this item is selected, the items above cannot be selected. An authorization for a use or disclosure of psychotherapy notes cannot be combined with another authorization.

Treatment dates to release: Date Range: From _____ To: _____

From: Chance House of East Tennessee

To: _____

I understand that this information will be used to determine present and future eligibility for probation, parole, bail bond, pretrial release or other diversion or conditional release process within criminal justice system.

This consent will remain in effect until, and will be revocable upon, the final disposition of my diversion or conditional release.

The consent for release of information is given freely, voluntarily, and without coercion. I understand my records are protected under Federal Regulations governing Confidentially of Alcohol and Drug Abuse Patient Records, 42 CFR, ("Part 2") and the Health Insurance Portability and Accountability Act of 1996 ("HIPPAA"), 45 CFR, Parts 160 and 164, and may be subject to re-disclosure by the recipient and no longer protected by law, except to the extent Part limits such disclosure.

I understand that Chance House of East Tennessee may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Resident/Client Signature _____ Date _____

Witness Signature _____ Date _____

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Authorization for Release of Information

(General)

NAME _____ DOB _____ SOCIAL SECURITY# _____

I hereby authorize the release of the following specific information: (check all item that apply)

Presence in Treatment	Aftercare Plans	Progress in Treatment
Medication Record	Psychiatric Evaluation	Psychosocial History
Admissions and Discharge Dates	Diagnosis	Discharge Summary
Physicians H & P	Labs & Ancillary Labs	HIV– Related Information
Complete Client File (excluding Psycho-therapy notes	Discharge Certificate	

OTHER Specify _____

Psychotherapy Notes:

_____

NOTE: If this item is selected, the items above cannot be selected. An authorization for a use or disclosure of psychotherapy notes cannot be combined with another authorization.

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