

APPROVAL Acceptance Let _____ Entrance _____
--

DDC WOMEN'S ENTRY ASSESSMENT

The individual applying to the waiting list has to fill out and sign this form.

Thank you for your inquiry about the DDC Women's Program. We are a Christ-centered, residential, 12-18 month recovery program. We are aiding individuals in redirecting their life by sharing God's values and principles. Our classes teach women with addiction to take responsibility for themselves and others while allowing God to reshape their lives. 2 Corinthians 5:17..."Therefore if anyone is in Christ he is a New Creation; the old has gone, the new has come."

Please be informed that in order for your name to be added to our waiting list the entry assessment form must be completed and returned. At that time your application will be reviewed and you will receive a letter in the mail of acceptance or denial (if denied a reason and referrals to other facilities will be given). In order for us to keep you on our list you will have to contact us every week by phone or through the mail! (If we do not hear from you, your name will be removed from the list.) Please have your affairs in order, realizing that we never know in advance when a bed might become available. When contacted, your bed will be held for 24 hours only. No exceptions.

NAME _____ TODAY'S DATE _____
 PHONE _____ ADDRESS _____

(Please list 2 methods of contact)

NAME _____ PHONE(_____) _____
 ADDRESS _____
 NAME _____ PHONE(_____) _____
 ADDRESS _____

What is currently happening in your life? _____

What is your prior work history? _____

Have you ever been to our recovery program? (If yes, please explain circumstances of you leaving or being dismissed. Please include the year that you were here.)

Are you willing to spend 12-18 months in a residential recovery? _____

LEGAL INFORMATION

ATTORNEY NAME _____ PHONE _____
ADDRESS _____
PO NAME _____ PHONE _____
ADDRESS _____
COURT REFERRAL OFFICER _____
ADDRESS _____

Have you ever been convicted of a sexual offense or do you currently have sexual charges pending? _____

Are you incarcerated? _____ Where? _____

Are you required by a judge to complete a recovery program? _____
Judge _____ Phone _____ Address _____

LIST ANY AND ALL CASES THAT YOU HAVE EVER BEEN ARRESTED FOR BELOW:

CHARGE: _____	DATE: _____	COUNTY: _____	COURT DATE: _____
CHARGE: _____	DATE: _____	COUNTY: _____	COURT DATE: _____
CHARGE: _____	DATE: _____	COUNTY: _____	COURT DATE: _____
CHARGE: _____	DATE: _____	COUNTY: _____	COURT DATE: _____
CHARGE: _____	DATE: _____	COUNTY: _____	COURT DATE: _____
CHARGE: _____	DATE: _____	COUNTY: _____	COURT DATE: _____

We do not act as your lawyer. If you are in jail, you will need your lawyer to do the legal work for you. We are unable to provide transportation from jail. Your lawyer may contact the Kim Upton, Program Director, for further information.

DRUG HISTORY

What is your drug of choice? _____ Do you consider yourself addicted? _____
Explain:

Our Program is not a detox facility. If you arrive at this facility and realize you need detox, we will not be able to hold your bed for you, however at the time of detox completion, with a release form from the physician, a place will be made available for you at the facility.

MEDICAL CHECKLIST

DO YOU HAVE PROBLEMS WITH ANY OF TH FOLLOWING? PLEASE CIRCLE ALL THAT APPLY:

- HIGH / LOW BLOOD PRESSURE
- KIDNEY / BLADDER
- ASTHMA
- DIABETES
- TUBERCULOSIS
- EPILEPSEY
- VENERIAL DISEASES
- MIGRAINE HEADACHES
- SKIN SORES
- TROUBLE BREATHING
- MENTAL ILLNESS (please specify diagnosis) _____
- OTHER (please explain) _____

List allergies _____ Are you disabled or handicap? _____

Do you have any long-standing health issues that cause you concern? _____
if so, specify: _____

Are you pregnant? _____ if so, how many months? _____

Do you receive disability, SSI, or any other funds from the government? _____
if so, what amount? _____

(Please note that if you receive assistance you will be required to pay \$200 per month while in our program)

Do you have insurance? (Medicare, Medicaid, BCBS, etc.) _____

LIST BELOW ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

MEDICATIONS / MG	DOSE	Rx DATE	QUANTITY	PHYSICIAN	REASON PRESCRIBED
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List any medication(s) you should be taking: (Prescribed) _____

I, _____ attest that the above information is true and that all medications are prescribed for the labeled purposes only and are currently the only medications I am using. **No exceptions will be made allowing the use of narcotic prescriptions while enrolled in the program.**

I _____ understand that this program is a Christian based organization. I am willing to commit to 12-18 months inpatient treatment. I am willing and able to sleep on a mattress on the floor, bunk bed, or cot. I understand that I will participate in the work therapy

program, in return for my recovery. If you are not able to physically and mentally participate in work therapy this program is not for you.

The \$200 intake fee is due upon acceptance. No exceptions. This fee is one time and is non-refundable.

Signature _____ Date _____
(By signing I agree to all above said statements and attest that all information given is true.)

Fees: Drug testing is \$12 per screen – twice per month

CLOTHING

RESTRICTED CLOTHING GUIDELINES: No sleeveless clothing, halter tops, tight fitting or figure fitting clothing, no slits in dresses/skirts/shorts. All shorts, skirts, and dresses must be knee length or no more than 1” above the knee.

Clothing Allowance

OUTFITS defined as shirts, shorts, pants, skirts, & dresses = 15

PAJAMAS/NIGHT CLOTHES including undershirt or shorts = 3

PURSES including book bags = 3 SHOES including house slippers = 6 BRAS=7

SOCKS = 10 PANTIES = 10 PANTY HOSE = UNLIMITED JACKETS =
including sweaters = 3

You will receive a letter of acceptance or denial, by mail. If this form is not filled out completely, your name will not be added to the waiting list. It will be mailed back to you for completion.

Please mail assessment form to the following:

**DDC Women
Attention: Kim Upton
PO Box 1621
Decatur, AL 35602**