GREENHOUSE APPLICATION FOR ADMISSION

Please allow 20-30 minutes to complete this application. Complete each section to the best of your ability. *If an area of the application does not apply, leave it blank or write NA (Not Applicable).*

Note: According to North Carolina Law (NCGS 14-208.16) The Greenhouse is not allowed to accept residents with a sex offense record. The home is located near an elementary school.

I. Applicant Information

Today's Date:___/___/_____

Date of Birth: ___/___/_____

Name:_____
(First Name) (Middle Name) (Last Name)

Name and Relationship of Representative Completing Form (If Other Than Applicant)

Name (First and Last):_____

Relationship:

Prison (Name): Email:	Address:	Phone #:
Rehabilitation Facility (Name): Email:	Address:	Phone #:
Best contact information for you: Email:	Address:	Phone #:
OPUS #:	Where did you grow up:	Who raised you?

High School (where)?

Year completed:

GED (where)?

Year completed:

College/Higher Education (where)?

Year completed or Hours completed:

Certifications (where)?

Year completed or Hours completed:

Last Place of Residence: State: Zip Code:
Spouse's Name: Address: Phone #:
Next of Kin: Address: Phone#:

II. Relationship Information

Relationship Status	Relationship Satisfaction (If currently in a relationship	Sexuality
☐ Single, Never married ☐ Separated for _____ years ☐ Widowed for _____ years ☐ Divorced for _____ years ☐ Married for _____ years ☐ Significant other for _____ years ☐ Partner for _____ years ☐ Relationship for _____ years ☐ Previous marriages? If yes, how many? ____ ☐ Never been in a serious relationship ☐ Not currently in a relationship ☐ Currently in a serious, non-marital, relationship	☐ Very satisfied with relationship ☐ Satisfied with relationship ☐ Somewhat satisfied with relationship ☐ Dissatisfied with relationship ☐ Very Dissatisfied with relationship	☐ Lesbian ☐ Bisexual ☐ Heterosexual ☐ Transexual ☐ Other: _____

Have you ever been diagnosed with or tested positive for a sexually transmitted disease?

- ☐ Yes
- ☐ No

If Yes, please check all that apply.

- ☐ HIV/AIDS
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Oral herpes
- ☐ Syphilis
- ☐ Other
- ☐ NA

III. Children

Complete your birth history information to the best of your ability.					
How many pregnancies have you experienced, if any?					
How many abortions have you experienced, if any?					
How many miscarriages or stillbirths have you experienced, if any?					
How many live births have you experienced, if any?					
How many living children do you currently have?					
1	**Child's Name**	**Age**	**Sex**	**Who cares for the child?**	**Do you have a relationship with the child?**
2					
3					
4					
5					
6					
7					
8					

If you have more children, please write their information on the back of the application.

IV. Family Medical History

Please check all boxes that apply. Complete this section to the best of your ability.						
	Mother	**Father**	**Sibling**	**Children**	**Maternal Grandparent**	**Paternal Grandparent**
Cancers						
Heart Disease						
Hypertension						
Obesity						
Diabetes						
Stroke						
Inflammatory Arthritis						
Inflammatory						

Bowel Disease						
Multiple Sclerosis						
Autoimmune Disease						
Irritable Bowel Syndrome						
Celiac Disease						
Asthma						
Eczema Psoriasis						
Food Allergies						
Sensory Sensitivities						
Dementia						
Parkinson's						
ALS or other Neuron disease						
Genetic Disorder						
Depression						
ADD/ADHD						
Autism						
Bipolar						
Schizophrenia						
Other Mental Health Illness						
Substance Abuse						

Family Mental Health Information (Not Including Yourself)

For boxes checked above, please provide additional information on any mental related health illness(es):

For boxes checked above, please provide additional information on type of substance(s) abused:

Childhood Family Environment. Please check all that apply; make notes to the side if you would like.

- ☐ Outstanding home environment:
- ☐ Normal home environment:
- ☐ Chaotic home environment:
- ☐ Witnessed physical/verbal/sexual abuse toward others (not including yourself):

V. Psychiatric History and Information

If you have ever been told that you have a mental health or psychiatric diagnosis, please write next to each item:

C = Current Condition P = Past Condition N = Never

____ Depression	____ Headaches and/or Migraines	____ Dementia/Alzheimer's
____ Anxiety	____ ADD/ADHD	____ Parkinson's Disease
____ Postpartum Depression	____ Insomnia	____ Multiple Sclerosis
____ Bipolar	____ Autism	____ Seizures
____ Schizophrenia	____ Memory Problems	____ Mood Adjustment

____ Obsessive Compulsive Disorder	____ Oppositional Defiant Disorder ____ Eating Disorder	Disorder ____ Panic Attacks ____ Other:

Have you ever received medication for a diagnosis? ____ Yes ____ No

If so, list the medication(s):

Are you currently taking medication for a diagnosis? *(If so, ensure that any medications are listed under current prescriptions and over-the-counter medications.)* ____ Yes ____ No

Have you ever had suicidal thoughts or attempts? ____ Yes ____ No

If you checked yes, when was the last time? Did you attempt suicide?

If you have ever been hospitalized for a mental health reason, use this section to provide further details including when, and how long you stayed.

If you have ever received outpatient care for a mental health reason, use this section to provide further details including when, how long you stayed, and what kind of care you received.

Use this section to provide further details on any ongoing mental health conditions, as applicable (anger, anxiety, depression, panic attacks, difficulty sleeping, eating disorder, etc.).

Describe any history of learning difficulties if applicable (reading, writing, math, technology, etc).
Describe any history of physical trauma you have experienced if applicable (injury caused by weapons, falls, hits, accidents, assaults, or other causes, etc.).
Describe any history of emotional trauma you have experienced if applicable (sudden death of a loved one, divorce, neglect, car accident, homelessness, poverty, abuse, etc.).

VI. Medical History and Information

Please write next to each item:
C = Current Condition P = Past Condition N = Never

____ Acid Reflux	____ Fluid Retention	____ Muscular Dystrophy
____ Alcohol Abuse	____ Excessive thirst	____ Nervous System Irritability
____ Anemia	____ Frequent Stressful	____ Nervousness
____ Asthma	Situations	____ Neuralgia
____ Autoimmune disorder	____ Frequent illness	____ Other Neurological
____ Bleeding Easily	____ Gout	____ Numbness of Fingers
____ High Blood Pressure	____ Hay Fever	____ Osteoarthritis
____ Low Blood Pressure	____ Hepatitis	____ Osteoporosis
____ Bruising Easily	____ Hearing difficulties	____ Fibromyalgia
____ Cancer	____ Ovarian cysts	____ Scoliosis
____ Chemotherapy	____ Poor Circulation	____ Shingles
____ Chronic cough	____ Intestinal Disorder	____ Shortness of Breath
____ Diabetes	____ Jaw Joint Disorder	____ Sleep Apnea
____ Difficulty with focus	(TMJ)	____ Skin Disorders
____ Drug Abuse	____ Kidney Problems	____ Speech Difficulties
____ Chronic Fatigue	____ Liver Disease	____ Slow Healing Sores
____ Cold Hands & Feet	____ Low Energy	____ Thyroid Disorder
____ Chronic pain	____ Meniere's Disease	____ Tuberculosis
____ COPD	(Vertigo)	____ Tumors

____ Glaucoma	____ Menstrual cramps ____ Multiple Sclerosis ____ Muscle Aches ____ Muscle Shaking (Tremors)	

If known, please list your blood type: _____

List any allergies. Please include reactions, and current treatment & management, if applicable.

Describe dental history and needs (fillings, root canals, tooth pain, Gingivitis, implants, bleeding gums, etc.).

Describe surgical history, if any (appendix removal, breast lumpectomy, facial surgery, hysterectomy, phalloplasty, cesarean birth, etc.).

Medical Restrictions

Do you have any assistive devices?
____ Cane ____ Walker ____ Wheelchair ____ Glasses ____ Hearing Aid
____ Other:

Do you have any chronic disabling conditions? If so, please explain.

Do you have any physical problems that limit your ability to work or navigate a workplace? If so, please explain:

Do you have any dietary restrictions/considerations? If so, please give details.

Other Medical Information

List any current medical and mental health diagnosis and treatment:

List all current prescriptions, over-the-counter medications, and supplements (include instructions and dosage frequency).

	Name	Purpose	Dose	Frequency	Instructions: (with food, by mouth, topical, etc.)
1					
2					
3					
4					
5					
6					

7					
8					
9					
10					
11					
12					
13					
14					
15					

Can you self - administer medications? ____ Yes ____ No
If no, please describe in detail:

VII. Substance Abuse History

Have you ever smoked? _____
How do you prefer to smoke? _____
What have you smoked? _____
If you currently smoke, how long have you smoked in your lifetime? _____
If you currently smoke, how often do you smoke? _____
If you currently smoke, about how much money do you spend each month on smoking? _____

In the following section, please list your primary drugs of addiction (including alcohol) in order of intensity of use:

	Drug	**Started Using**	**Frequency of Use**	**Last Used**
1	Drug: Use for _____ years			
2	Drug: Use for _____ years			
3	Drug: Use for _____ years			
4	Drug: Use for _____ years			

5	Drug: Use for _____ years			
6	Drug: Use for _____ years			
7	Drug: Use for _____ years			

If you have ever received treatment for substance abuse, use the section below to provide further details in order of most recent.

	Type of Treatment	**Where**	**When**	**How Long**
1				
2				
3				
4				

Additional Information, if any:

VIII. Incarceration Information

What crime were you charged with?	
What crime were you convicted of?	
Date you entered prison or jail?	Release date:
Release Special Conditions:	
Case/Social Worker:	Probation Officer:
Parole Review Date:	Number of Reviews:
List All Write-Ups and How Resolved:	

List All Prison Programs Completed:
Are you currently attending Bible Study? ____ Yes ____ No Name of Program: _____ Name of Discussion Leader: _____
List any Faith-Based Programs Attended:
Have you had any prior incarcerations? ____ Yes ____ No

If yes, how many? ____	If yes, list the location or name(s) of the prison facility:
What was the longest period of incarceration?	How many many months/years have you been incarcerated in TOTAL? _____

IX. Financial Information

Detail any restitution obligations:
Detail any current debts or loans:
Detail all financial obligations upon release:

Detail all financial resources (e.g. benefits or services for developmental, physical, or mental disability, food assistance, housing assistance, grants, family assistance)

X. Employment Information

Provide employment history starting with the most recent job and proceeding backward in time.		
Employer 1:	This was a work-release job.	Last Position Held:
City:	State:	From: To:
Reason for Leaving:		
Employer 2:	This was a work-release job.	Last Position Held:
City:	State:	From: To:
Reason for Leaving:		
Employer 3:	This was a work-release job.	Last Position Held:
City:	State:	From: To:
Reason for Leaving:		
Employer 4:	This was a work-release job.	Last Position Held:
City:	State:	From: To:
Reason for Leaving:		
List all prison work assignments:		

List all employment skills:
What are your employment plans?
What is your alternative home/living plan?
What current goals do you have?
What are your hobbies?

XI. References

List References not related to you (at least two).		
Name:		Email:
Address:		Phone:
City:	State:	Zip Code:
Name:		Email:
Address:		Phone:
City:	State:	Zip Code:

XII. Personal Comments

Give a brief explanation telling how you came to know Jesus Christ and why you are applying to the Greenhouse - a faith based 18 month transition home for female returning citizens.

XIII. Disclosure Notice

I acknowledge that the information provided in this application is truthful and complete and I understand that if it is later determined that false or inaccurate information has been given, my application may be rejected or I may be dismissed from the Greenhouse.	
Signature of Applicant:	Date: