



Application for Program Participation

Date: _____

Have you ever been a client of the New Life Pregnancy Center? Yes No

Have you ever participated in the New Life Transitional Program? Yes No

How did you find out about New Life Transitional Program?

Friend Family Phone Book Website Program Brochure Agency
Church Pregnancy Center Past/Current Client Other _____

IMPORTANT INSTRUCTIONS

It is very important that you, as the applicant, answer all questions with accurate information. We will ask you about your citizenship and immigration status, and for your social security number. All information you provide on this application will be kept strictly confidential and not released or shared with any outside parties. The information you provide will be used to: verify identity, verify income, and assess compliance with program guidelines.

General Information

Name: _____ Cell Phone #: _____

Home Phone #: _____ Other Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Current address is a: ___ Shelter ___ Residential Treatment ___ Private Home
___ Other - if other, please explain: _____

Email: _____

Date of Birth: _____ SS#: _____

Marital Status: Single Married Separated Divorced

If divorced or separated, please give dates and describe past/current situation:

Are you currently living with any adults (relationship or not)? Yes No

If yes, then who are you living with? _____

Religious Preference: _____

Spiritual Beliefs: _____

Church you attend: _____

Are there any circumstances in your life that ABCS should be aware of?

Domestic Violence Parole Probation Restraining Orders

Other: _____

PO's Name and Phone #: _____

If applicable, please list ALL arrests, convictions, sentences, previous incarcerations, and/or your probation history. Include dates and locations:

Employment Information

Employer: _____

Position Held/Responsibilities: _____

Supervisor: _____ Employer Phone #: _____

May ABCS contact your employer? Yes No

If no, please explain _____

Hours/Week: _____ Employed there since: _____

If married, is your spouse employed? Yes No

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____

Phone # for Spouse's Employer: _____ Employed there since: _____

Are you legally able to be employed in the United States of America? Yes No

Work Experience

Please list ALL of your previous jobs, work skills used/learned during your employment, and estimated time at that job. We will NOT be contacting these employers; we just want to get an accurate picture of your skill set.

Employer	Skills Learned/Used	Time at Job

Dependents Information (Please fill out if you have children)

Women Only

Are you currently pregnant? Yes No Unsure

(If unsure, a pregnancy test is required for verification.)

If pregnant, are you currently receiving prenatal care? Yes No

Name of Physician: _____ Phone #: _____

If yes, how far along are you? _____ Estimated Due Date: _____

Have you been pregnant before? Yes No Total # of Pregnancies: _____

Have you ever had a miscarriage? Yes No How many? _____

Have you ever had an abortion? Yes No How many? _____

How far along? _____ Type: _____

Have you received counseling for any miscarriages or abortions? Yes No

Men and Women

If separated, is the father/mother of your children involved? Yes No
Do you currently have full custody of all your children? Yes No
If no, do you have full custody of any of your children? Yes No
What are the names of the children you have full custody of?

Do you currently have partial custody of any of your children? Yes No
If so, what are the names of the children you have partial custody of?

Do you currently not have custody of any of your children? Yes No
If so, what are the names and ages of the children you DO NOT have custody of?

Please describe any shared custody or no custody situations:

Please list the names and birthdates of the child(ren) living with you part or full time.

Child's Full Name	Sex	Date of Birth

Are any of your children currently involved with DCS? Yes No

If DCS is involved, please provide your DCS case worker's information:

Name: _____ Phone #: _____

Have any of your children ever had a history with DCS? If so, please explain:

Do any of your children have any special circumstances that we should be aware of?

Housing and Transportation Information

Do you own or rent your residence? Own Rent N/A

Is your name on the lease/mortgage of your current residence? Yes No

Name of landlord or property manager: _____

Phone # for landlord or property manager: _____

What is your usual method of transportation? _____

Educational Information

What is the highest level of education you have completed?

High School GED Some College Graduated from College

Vocational Training None of the above

Do you currently attend school or vocational training? Yes No

If yes, what is the name of the school/program? _____

May ABCS contact your school? Yes No

If no, please explain _____

Name and phone # for school advisor: _____

Current Health Conditions

Please include any physical and/or mental health conditions and medications prescribed when answering the following questions.

Do you have a **history** with any of the following?

Drug Abuse Alcohol Abuse Smoking Mental Health Other

If other, please explain: _____

Are you **currently** involved with/experiencing any of the following?

Drug Abuse Alcohol Abuse Smoking Mental Health Other

If other, please explain: _____

Have you ever been in treatment, or currently in treatment for any of the above?

Yes No If yes, what date did you enter? _____

If yes, please explain what you received/are receiving treatment for:

Date Released: _____ Program Completed: Yes No

If no, please explain: _____

Are you currently taking any prescription medications? Yes No

Name of Medication	Reason for this Medication	How long have you been taking this medication?

Is there anything else about you, your family, employment, or financial situation that you would like to share?

In case of emergency, notify (please provide 3):

Name: _____ Relationship: _____

Phone _____ Other Phone: _____

Name: _____ Relationship: _____

Phone _____ Other Phone: _____

Name: _____ Relationship: _____

Phone _____ Other Phone: _____

Financial Information

Please explain your current financial situation:

Does your monthly income, cash, and bank account balance cover your monthly rent/mortgage, utilities, and other responsibilities? Yes No

Are you currently receiving any of the following? (Please circle)

Child Care Assistance

AHCCCS Medical Insurance

Cash Assistance

Do you have a savings account? Yes No If yes, amount currently in account \$_____

Do you have a checking account? Yes No If yes, amount currently in account \$_____

Do you have any cash saved? Yes No If yes, amount currently saved \$_____

Do you receive **or expect** to receive money from any of the following:

Cash Assistance Yes No Amount \$ _____ /month

Food Stamps Yes No Amount \$ _____ /month

Unemployment Insurance Yes No Amount \$ _____ /month

Relative/Church Yes No Amount \$ _____ /month

Child Support Yes No Amount \$ _____ /month

Disability Yes No Amount \$ _____ /month

Tribal Money Yes No Amount \$ _____ /month

Social Security Yes No Amount \$ _____ /month

Retirement/Pension Yes No Amount \$ _____ /month

Gifts/Loans Yes No Amount \$ _____ /month

Scholarships, Grants/Loans Yes No Amount \$ _____ /month

Government Checks Yes No Amount \$ _____ /month

Workers Comp/Industrial Yes No Amount \$ _____ /month

Other Yes No Amount \$ _____ /month

Gross Monthly Household Income (Totals from above)

Employment Income: Self \$_____ /month Spouse \$_____ /month

Child Support Received: Self \$_____ /month Spouse \$_____ /month

Cash Assistance: Self \$_____ /month Spouse \$_____ /month

Food Assistance: Self \$_____ /month Spouse \$_____ /month

Other: Self \$_____ /month Spouse \$_____ /month

Total Monthly Household Income: \$_____

Personal and Professional References

The New Life Transitional Program seeks out only the most committed individuals who are dedicated to significant, long term life change. For this reason, NLTP requests personal and/or professional references for each applicant. The case manager and/or the statewide program director **WILL** call and interview each reference listed, so please do not list references who you do not wish to be interviewed. We understand the need for privacy and will make every attempt to maintain the applicant's privacy during the reference check process. However, we will not misrepresent who we are or what we do, so do not list individuals if you do not want them to know you are seeking participation in this program.

References can be family members, friends, or co-workers as long as you have known them for **at least three years**. Please provide at least one family member as a reference. Make sure all the contact information is complete and accurate. If we are unable to contact one of your references, we will contact you to provide an alternate reference.

Name: _____ Phone Number: _____

Address: _____

How do you know this individual? _____

How long have you known this individual? _____

Name: _____ Phone Number: _____

Address: _____

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Address: _____

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Address: _____

How do you know this individual? _____

How long have you known this individual? _____

General Interview Questions

Please answer in detail; you may use an additional sheet of paper if needed

1. Why are you applying to participate in the New Life Transitional Program?
2. What do you really like about yourself?
3. What are your strengths?
4. What areas of your life would you like to work on while in this program?
5. On a scale of 1 to 10 (with 1 being the lowest and 10 being the highest), how committed are you to significant, long term life change and why?

6. On a scale of 1 to 10 (with 1 being not successful and 10 being very successful), how **successful** do you expect to be at maintaining significant life change and why?

7. Why do you think you are where you are in your life?

8. What kind of support system do you have?

9. Is there anything about yourself that was not mentioned that you would like us to know?

New Life Transitional Program

Release of Information

I, _____, hereby agree that information about me may be released to _____, an employee of Arizona Baptist Children’s Services.

The information which is released may be verbal or in writing. I further agree that I will not hold the individual or organization liable for releasing information about me when this release form is provided. A copy of this release may be kept on file for future reference and use. This release of information form will be in effect for 24 months from the date of my signature.

Signature

Date

Printed Name of Applicant

Date of Birth

Please list any aliases used in the spaces below:

By Signing this Application

- I authorize New Life Transitional Program to contact my current employer to obtain wage information and verify employment.
- I affirm that the statements made regarding occupants in my home, income, assets, property and all other information is true and correct to the best of my knowledge, and that I have not withheld any information.
- I authorize New Life Transitional Program to run a background check to verify any existing criminal record.
- I understand that New Life Transitional Program will contact my references to assess my ability to commit to the program.
- I understand that New Life Transitional Program will periodically contact my employer to ensure that I am maintaining minimum employment requirements while in the program.
- I agree to notify the case manager immediately of any changes in employment status.

Applicant's Signature _____ Date _____

Printed Name of Applicant _____

Case Manager's Signature _____ Date _____

Printed Name of Case Manager _____

Arizona Baptist Children's Services

I hereby authorize and release Arizona Baptist Children's Services, its successors and assigns, to reproduce, circulate and use my likeness and/or my child's likeness, as well as my recorded statements, for promotion, education, fundraising and advertising in connection with its business. I understand that my action is voluntary and in no way necessary to receive or continue to receive services from the agency.

I prefer that: (check one)

First names only be used

A fictitious name be used

No name at all be used

OR I give permission for my full, legal name to be disclosed

Printed Applicant's Name

Printed Child's Name

Printed Child's Name

Printed Child's Name

Printed Child's Name

Printed Child's Name

Applicant and/or Guardian's Signature

Date

New Life Transitional Program Participation Agreement

I, _____ as a participant in the New Life Transitional Program, agree to comply with the requirements and guidelines stated in this agreement. I understand that my participation in this program may be immediately terminated for non-compliance. If my privileges for participation in this program are revoked, I understand that I will not receive any further resources New Life Transitional Program.

I understand that my participation in this program is voluntary and that I am free to quit the program at any time. I realize that if I quit the program, I will lose all privileges provided to me by my participation in the program. In the event that I choose to leave the program, I will notify my case manager in writing.

Applicant Signature

Date

Case Manager Signature

Date

Statewide Director Signature

Date

Arizona Baptist Children's Services
1779 N. Alvernon Way
Tucson, AZ 85712

Re: Participant of the New Life Transitional Program

I, _____ agree to cooperate with Arizona Baptist Children's Services when asked to do random drug tests, conducted on the premises or at Concentra for drug use screening. The tests will be at the expense of Arizona Baptist Children's Services.

I also understand that if there is suspicion or evidence of my using any drugs or alcohol while I am a participant of the New Life Transitional Program, I will be dismissed immediately from the program and forfeit any further housing allowances.

Applicant Signature

Date

Case Manager Signature

Date

Statewide Director Signature

Date



New Life Counseling Services

I, _____, as a participant in the New Life Transitional Program, agree to comply with the guidelines associated with the New Life Counseling Services as outlined below.

Each participant in the New Life Transitional Program agrees to attend counseling sessions provided through New Life Counseling. Furthermore, participants agree to abide by the following guidelines associated with the New Life Counseling Services:

- **UNEXCUSED or "NO SHOW" APPOINTMENTS** – A **24 hour** notice is required when canceling or rescheduling an appointment. If you experience a scheduling emergency, call your mentor as soon as possible. If you do not provide adequate notice or attend your scheduled appointment a \$25 fee will be billed to you for the missing appointment. For residency clients this fee will be broken down to a \$15 fee and \$10 deducted from their earned rent credit. Further appointments with your counselor will be on hold till you pay the fee. Arriving more than 15 minutes late for a scheduled appointment will be considered a "no show" appointment.
- **EXCUSED ABSENCE CLASS FEE** – As a participant in the New Life Transitional Program, counseling sessions provided by New Life Counseling Services are considered a class. For all participants in the housing program missed counseling appointments that are excused will result in a \$10 deduction from the rent credit.

Participant's Signature

Date

Printed Name

Case Manager's Signature

Date

Statewide Director's Signature

Date



Sexual Purity Agreement

I, _____, as a participant in the New Life Transitional Program, agree to comply with the Sexual Purity Agreement as outlined below.

Participant in the New Life Transitional Program agree to adhere to the following standards:

- Participants will not engage in sexual relations while enrolled in the New Life Transitional Program, with the exception of married couples.
- Participants living on the New Life Transitional Program property are required to submit a request for approval for **ANY** overnight guests **PRIOR** to the guest arriving.
- NLTP participants may NOT be in a relationship with any other NLTP participants while enrolled in the program.
- Violation of any of these standards will be grounds for immediate eviction from the New Life Transitional Program property, in which participants will have 48 hours to vacate the property.
- Violation of any of these standards will be grounds for possible expulsion from the New Life Transitional Program.

Please be aware that ABCS is not implementing these guidelines to control your life in any way; we strongly believe that intimate relationships should **ONLY** be in the context of marriage. We believe that participating in such behavior would be detrimental to your success in the New Life Transitional Program.

I certify that I understand the standards of sexual purity agreement and the requirements to participate in the New Life Transitional Program and agree to adhere to these standards.

Applicant's Signature

Date

Case Manager's Signature

Date

Statewide Director's Signature

Date