

CONTACT INFORMATION

Today's Date	
Name	
Current Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	

IDENTIFICATION & BACKGROUND

Age	
Birth Date	
Social Security Number	
Ethnicity	
Are you currently receiving Medicaid?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you currently receiving food stamps?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, what is the monthly amount?	\$
Are you currently receiving WIC?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you receiving disability or social security?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, what is the monthly amount?	\$
Other sources of income?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, what is the source of income?	

PREGNANCY

Are you pregnant now?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, what is your due date?	
Who is the father of your baby? (full name)	
What is your relationship status?	
Is he supportive of you living at Bethlehem House?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you been pregnant before?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, list other children and who they are cared for by:	
1.	2.
3.	4.
5.	6.
Have any of your pregnancies ended in miscarriage?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, how many?	
Have any of your pregnancies ended in abortion?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, how many?	

FAMILY HISTORY

Your Mother's Information:

Name		
Occupation		
Address		
Phone (h):	Phone (c) :	Phone (w):
Email		

Describe your relationship with your mother:

Your Father's Information:

Name		
Occupation		
Address		
Phone (h):	Phone (c) :	Phone (w):
Email		

Describe your relationship with your father:

Do your parents live together?	<input type="checkbox"/> yes <input type="checkbox"/> no
With whom do/did you live with?	<input type="checkbox"/> with Mom, at ages: <input type="checkbox"/> with Dad, at ages: <input type="checkbox"/> Other Name: Relationship: At what ages?
Do you have siblings?	<input type="checkbox"/> yes <input type="checkbox"/> no

If yes, list your brothers and sisters (indicate if this is a step/half brother or sister):

Name	Age	Address
1.		
2.		
3.		
4.		
5.		
6.		

Additional comments on your family history?

PERSONAL HISTORY | Educational Background

Grade last completed?	
Do you have a diploma or GED?	<input type="checkbox"/> yes <input type="checkbox"/> no
Where did you attend high school?	
Number of schools you attended during the course of elementary, middle and high school:	
Do you have college/vocational training?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, explain:	
Are you currently attending school?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, explain:	

PERSONAL HISTORY | Work Experience

List your last three places of employment, starting with the most recent:

Where:	
When:	
Your responsibilities:	
Reason for leaving:	
Where:	
When:	
Your responsibilities:	
Reason for leaving:	
Where:	
When:	
Your responsibilities:	
Reason for leaving:	

PERSONAL HISTORY | Spiritual & Faith

Do you believe in God?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you attend church regularly?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, where (include denomination)?	
Do you attend church services with family members?	<input type="checkbox"/> yes <input type="checkbox"/> no
List the names and relationships of those you attend church services with:	

PERSONAL HISTORY | Relationships

Indicate your status	<input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> in a relationship <input type="checkbox"/> divorced
If married or in a relationship, is he the father of your baby?	<input type="checkbox"/> yes <input type="checkbox"/> no
How long have you been together?	
How would you describe him?	
If no, describe your relationship with the father of your child/children (include his name):	

PERSONAL HISTORY | Domestic Violence

In the last six months, indicate people you have had a problem with:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother(s) <input type="checkbox"/> Sister(s) <input type="checkbox"/> Other family:
Have any of these people ever abused you?	<input type="checkbox"/> yes <input type="checkbox"/> no
Indicate abuse you have experienced:	
Emotional (when someone made you feel bad through harsh words or verbal intimidation):	
Physical (cause you physical harm):	
Sexual (forced to have sex, or been touched in are/ways you didn't want to be):	
Has a past or present boyfriend ever:	
<input type="checkbox"/> hit, pushed or physically intimidated you	
<input type="checkbox"/> verbally abused you, threatened you or intimidated you	
<input type="checkbox"/> forced you to have sex or perform sexual acts against your will	
Have you ever had, or do you currently have, a restraining order against anyone?	<input type="checkbox"/> yes <input type="checkbox"/> no
Is there any reason to believe that a current or past boyfriend would want to hurt you?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, explain:	

PERSONAL HISTORY | Legal

How many times in your life have you been charged with:		
_____ Shoplifting	_____ Vandalism	_____ Theft
_____ Forgery	_____ Child Neglect	_____ Child Abuse
_____ Failure to appear	_____ DUI/DWI	_____ Other:
Are you currently on probation, parole or court supervision?	<input type="checkbox"/> yes <input type="checkbox"/> no	
If yes, explain:		

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Are you currently awaiting charges, sentencing or trial	<input type="checkbox"/> yes <input type="checkbox"/> no
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If yes, explain:

Is there currently a warrant out for your arrest?	<input type="checkbox"/> yes <input type="checkbox"/> no
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Do you have charges pending?	<input type="checkbox"/> yes <input type="checkbox"/> no
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Charge	Court Date	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had previous arrests?	<input type="checkbox"/> yes <input type="checkbox"/> no
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What were the charges and when were they filed?

Charge	Date
_____	_____
_____	_____
_____	_____

Do you have any outstanding traffic tickets	<input type="checkbox"/> yes <input type="checkbox"/> no
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If yes, explain:

Have you ever been in jail or a juvenile detention program?	<input type="checkbox"/> yes <input type="checkbox"/> no
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If yes, explain:

Are you currently involved with Child Protective Services (CPS)?	<input type="checkbox"/> yes <input type="checkbox"/> no
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If yes, explain:

HOUSING HISTORY

In the last year, what were your usual living arrangements? Check all that apply.

with family with friends group home
 alone in a shelter no stable home
 boyfriend Other: _____

Number of times you moved in the past year:	_____
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Number of times you have moved since you were born:	_____
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Have you ever lived in a group home?	<input type="checkbox"/> yes <input type="checkbox"/> no
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If yes, indicate the name of the home or facility:

List dates and your age when you lived there:

Have you ever been in foster care?	<input type="checkbox"/> yes <input type="checkbox"/> no
How many foster homes have you lived in?	
List dates and your age when you lived there:	

PRACTICAL SUPPORTS

What do you do for transportation?	
Do you have a driver's license?	
Do you have a State I.D.?	
Do you have a copy of your birth certificate?	
Do you have a Social Security card?	
If children, do you have their Social Security cards?	

SUBSTANCE ABUSE

Do you currently smoke?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever smoked?	<input type="checkbox"/> yes <input type="checkbox"/> no
List the date you started smoking:	
List the date you stopped smoking:	
How many times in the last three months have you used:	
_____ Alcohol _____ Cocaine _____ Marijuana _____ Amphetamines	
Other:	
At what age was your first alcohol use?	
Describe your alcohol use (recreational, when alone, at parties, etc.):	

Have you ever been treated for an alcohol or drug problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes, specify: _____ Alcohol _____ Drug Which Drug? _____	
Did you undergo detoxification?	<input type="checkbox"/> yes <input type="checkbox"/> no
Did you complete detox treatment?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes: How many times? For what? Places and dates:	
If no, explain:	
Did you undergo rehabilitation?	<input type="checkbox"/> yes <input type="checkbox"/> no
If yes: How many times? For what? Places and dates:	
If no, explain:	
Do you think you may have a current problem with alcohol use that has, so far, gone untreated?	<input type="checkbox"/> yes <input type="checkbox"/> no
Explain:	
Do you think you may have a current drug addiction that has, so far, gone untreated?	<input type="checkbox"/> yes <input type="checkbox"/> no
Explain:	

MENTAL HEALTH HISTORY

Do you suffer from any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> nervous breakdown | <input type="checkbox"/> anxiety disorder | <input type="checkbox"/> depression |
| <input type="checkbox"/> memory loss | <input type="checkbox"/> Bipolar | <input type="checkbox"/> violent behavior |
| <input type="checkbox"/> suicide attempt | <input type="checkbox"/> panic attacks | <input type="checkbox"/> Other: |

Has anyone in your family ever been diagnosed with a mental disorder?	<input type="checkbox"/> yes <input type="checkbox"/> no
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If yes, who and what disorder?

Are you now being treated, or have you ever been treated for emotional or psychological problems	<input type="checkbox"/> yes <input type="checkbox"/> no
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If yes, explain:

Have you ever been prescribed medications to be taken for an emotional or psychological problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
--	--

If yes, complete the following:

Medication Prescribed	Doctor or clinic that prescribed	Date
_____	_____	_____
_____	_____	_____

Are you currently taking any medications for an emotional or psychological problem?	<input type="checkbox"/> yes <input type="checkbox"/> no
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If yes, complete the following:

Medication	Dosage	Doctor or clinic that prescribed
_____	_____	_____

Have you ever attended counseling?	<input type="checkbox"/> yes <input type="checkbox"/> no
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Are you currently seeing a counselor?	<input type="checkbox"/> yes <input type="checkbox"/> no
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If yes, list counselor's name:	
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This completes Section I of the application. Thank you. You're almost there!
Please turn to Section II (page 8) and complete the essay questions and reference form.

ESSAY QUESTIONS

Please answer the questions as thoroughly as possible. Take your time and use the back of these sheets if necessary. Some of questions may have been asked elsewhere in this application, but take this opportunity to share additional details.

1. Have you ever been involved in gang activity? Explain:

2. Have you ever been physically, emotionally, or sexually abused? How old were you? How do you believe it has affected your life?

3. Describe your childhood (i.e. safe/unsafe, healthy/unhealthy, lonely, happy):

4. What do you do when you feel anxious or upset?

5. How have you coped with crisis in the past?

6. Who do you count on for emotional support?

7. Do you have other children in foster care? Is your CPS case open?

8. How long have you been sexually active?

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9. Have you ever attempted suicide? How old were you? Explain what happened:

10. Describe your religious background and beliefs:

11. How do you typically respond to authority or authority figures (i.e. teachers, police officers, a boss)?

12. How do you deal with anger (how do you act when you are angry)?

13. List your hobbies and interests:

14. Tell us why you wish to live at Bethlehem House?

15. What are your goals? Where do you see yourself in two years? In five years?

I hereby certify that the statements and information in this application form are true and correct to the best of my knowledge and belief, and I authorize Bethlehem House to investigate all statements or other information contained in this application form and any attachments submitted with it.

Applicant Signature

Date

LIST OF REFERENCES

List the name, relationship and phone number of your references.

NAME	RELATIONSHIP	PHONE
		()
		()
		()
		()

EXPECTATIONS OF RESIDENCY WHILE LIVING AT BETHLEHEM HOUSE

All residents are expected to be drug and alcohol free while at the Bethlehem House. Weekly drug-testing is required.

Everyone will be awake and downstairs no later than 9:00 am (unless health warrants or pre-approved by staff)

Everyone will attend all scheduled classes, activities and programs at Bethlehem House.

All residents will have to work, be in school, or volunteering during the week.

All residents will take turns doing house chores and preparing evening meals for the house. This is a required weekly policy. Make dinner weekly and complete your chore nightly.

The women are expected to be at Bethlehem House for dinner Monday through Thursday and Sunday evenings. Unless approved absence by Gina Tomes.

The women can stay up to 15 weeks after they have their baby. To prepare for their departure at 15 weeks, you will be actively looking for housing and saving your money. Staff can provide help with saving your money and help you access various housing resources in the area.

The women will keep scheduled appointments. They are responsible for their own transportation. Bus passes are available.

The women will notify staff of pertinent doctor instructions and provide written proof of instructions.

All residents will be back at Bethlehem House by 9:00 pm Monday through Thursday and 11:00 p.m. Fridays and Saturdays. If they are running late, they need to telephone the Overnight Coordinator and be back within the hour. Curfew hours are required to meet.

The women will limit their time on the resident hall telephone to 10 min. calls (unless there is no one else expecting a call). There will be no resident hall telephone use after 11:00 pm. If the women have cell phones, they are not to use them in the bedroom area after 11:00 pm or before 9:00 am.

All residents are expected to abide by the rules put forth by Bethlehem House. Infractions of these rules may result in the woman being asked to transition out.

All residents are required to connect with the following resources within the first week of moving into Bethlehem House:

- Visiting Nurses Association (Love & learn) (402) 342-5566
- If you do not have healthcare established contact: Olsen Center at UNMC (402) 559-4500
Connect with Kris Severe.
- MOMMs mentoring program – part of the Bethlehem House family life curriculum.

Applicant Signature

Date