

**THE GLORY HOUSE
APPLICATION FOR ADMISSION**

4000 SOUTH WEST AVENUE
PO BOX 88145
SIOUX FALLS, SD 57109-8145
(605) 332-3273 FAX (605) 332-6410

Name: _____ Social Security #: _____ Date Submitted: _____

Home Address: _____ Phone#: _____
(street, city, state, zip code)

Date of Birth: _____ Place of Birth: _____

*Race or Ethnic Origin: _____ Gender: _____ Male _____ Female

In Case of Emergency Notify:

Name: _____ Phone #: _____

Address: _____

Relationship to above person: _____

Referred by: _____

Reason for Admission (circle one): Work Release, Self Admit, State Parole/Probation, Federal Probation,
Federal Supervised Release, Federal Pre-Trial, BOP Custody

STATE/FEDERAL/OTHER IDENTIFICATION #: _____

ARE YOU WILLING TO ABSTAIN FROM ALL ALCOHOL USE WHILE A RESIDENT OF THE GLORY HOUSE?
_____ YES _____ NO

ARE YOU WILLING TO ABSTAIN FROM THE USE OF DRUGS (INCLUDING MARIJUANA) WHILE A RESIDENT OF
THE GLORY HOUSE? _____ YES _____ NO

*Glory House does not discriminate based on race, color, gender, age, religion, national origin, marital status, political
belief, mental or physical handicap. Government funding agencies require this information for statistical purposes only.

For Glory House office use only:

Legal Status: _____

Jurisdiction: _____

Conditions of Commitment: _____

CHEMICAL USE HISTORY

Have you ever had a previous treatment for chemical dependency? Yes____ No____

When: Month Year	Where: Name of Facility and Address	Completed? Yes/No	Inpatient Treatment	Outpatient Treatment	Length of Sobriety After Treatment

ALCOHOL USE:

What was your age of first use of alcohol, with whom? _____

How old were you when you started drinking on a regular basis? _____

What was the progression of use (age, amount, frequency)? _____

Ever been arrested for drinking (when, where, why)?: _____

How many DWI/DUI arrests in the last 5 years? _____

Longest period of sobriety in the last 5 years? _____

What is your usual amount to use? _____

What is your maximum amount used? _____

When was your last drink of alcohol (date, amount, with whom, what drank)? _____

Where do you usually drink (circle all that apply)? Home, Work, Bars, Streets

Do you usually drink (circle all that apply)? Alone, With Friends, With Family

Have you established a program of sobriety? _____

Do you feel you have or have had a problem with alcohol? Yes No

If yes, how long has your alcohol use been causing you problems? _____

Have you ever had to go to an emergency room or physician's office for an alcohol related illness?

or accident? Yes____ No____

If yes, explain _____

Have you ever been hospitalized for alcohol intoxication or withdrawal? Yes____ No____

If yes, explain _____

Have You Ever Experienced The Following Symptoms Due to Alcohol Use?	Yes	No
Tremors of hands, tongue, or eyelids?		
Nausea and/or vomiting		
Depression/weakness		
Autonomic hyperactivity (sweating, elevated blood pressure)		
Anxiety/nervousness		
Depressed moods		
Irritability		
Hallucinations and/or illusions		
Headaches		
Insomnia		
Blackouts		
Used alcohol to relieve or avoid withdrawal symptoms		
Shakes (after heavy drinking)		
Need more to achieve intoxication or desired effect (tolerance)		
Markedly diminished effect with continued use of same amount		
Overdose		
Tried to slow down or stop drinking		
Drank more than you intended to		
Stayed drunk for more than one day		
Seizures		
Cravings (wanting alcohol)		
Alcohol poisoning (passing out)		
Gone without food to drink		
Fired from work due to alcohol use		
Just quit going to work		
Suspended from work due to your alcohol use		
Quit a hobby or recreational activity to drink or because of it		
Used alcohol in dangerous situations (swimming, driving, machinery)		
Used alcohol before or during work		
Warnings due to your alcohol use from employer		
Physical fights while under the influence of alcohol		
Involved in alcohol-related auto accidents		
Involved in accidental falls while under the influence of alcohol		
Injured in any way (explain)		
Has alcohol use created family problems		
Has alcohol use created problems with your children		
Has alcohol use created problems with your friends		
Has alcohol created problems with extended family		
Alcohol-related health problems (liver, kidneys, kidneys, throat, mouth)		

CANNABIS/HASHISH USE:

Have you ever used marijuana, THC, pot, hashish, etc.: Yes_____ No_____

(the following are not applicable if the above was answered "no.")

Name of Drug	Age first used	Method of use	Frequency of use	Duration of use	Usual amount consumed	Maximum amount consumed	Date of last use

Have you ever experienced the following with use or after using cannabis/hashish?	Yes	No
Chronic cough		
Headache		
Muscle cramps		
Decreased exercise tolerance		
Bronchitis		
Irritability		
Sleep disturbances		
Increased heart rate		
Depressed moods		
Cravings		
Need more to get high (tolerance)		
Quit a hobby or recreational activity to use or because of it		
Used in dangerous situations (swimming, driving, machinery)		
Fired from work due to use		
Used before or during work		
Tried to slow down or stop		
Involved in fights (explain)		
Involved in accidental falls (explain)		
Injured in any way (explain)		
Family problems from using		
Problems with your children from using		
Extended family problems		
Problems associated with your friends		
Health problems from using (liver, kidneys, stomach, throat, mouth)		

COCAINE USE:

Have you ever used crack, coke, powder, white, snow, flake, etc.? Yes_____ No_____

(the following are not applicable if the above was answered "no.")

Name of Drug	Age first used	Method of use	Frequency of use	Duration of use	Usual amount consumed	Maximum amount consumed	Date of last use

Have you ever experienced hallucinations or delusions while under the influence of cocaine? Yes_____ No_____

Have you ever seen things that other people couldn't see, or heard things other people couldn't hear while under the influence of cocaine? Yes_____ No_____

Have you ever experienced the following with use or after using cocaine?	Yes	No
Fatigue		
Nausea/vomiting		
Depression		
Sweating/chills		
Irritability		
Preoccupation with obtaining cocaine		
Agitation		
Cravings		
Insomnia/hypersomnia		
Anxiety		
Increased appetite		
Vivid/unpleasant dreams		
Stayed high for more than one day		
Used more or for longer periods of time than intended		
Used more to relieve or avoid withdrawal symptoms		
Problems with your family due to using		
Problems with your children due to using		
Problems with your extended family due to using		
Problems with your friends due to using		
Problems with your health due to using (liver, kidneys, stomach, throat, mouth)		

HALLUCINOGEN USE:

Have you ever used LSD, acid, DMT, peyote, buttons, mushrooms, mescaline, psilocybin, etc.? Yes_____ No_____

(the following are not applicable if the above was answered "no.")

Name of Drug	Age first used	Method of use	Frequency of use	Duration of use	Usual amount consumed	Maximum amount consumed	Date of last use

Have you ever experienced the following with use or after using hallucinogens?	Yes	No
Marked anxiety or depression		
Fear of losing your mind		
Paranoid ideations		
Impaired judgment		
Impaired social or occupational functioning		
Illusions and/or hallucinations		
Pupillary dilation		
Sweating		
Palpitations		
Blurring of vision		
Tremors		
Perceptual changes occurring in a state of full wakefulness and alertness		
Depersonalization		
Derealization		
Incoordination		
Have you ever had a flashback		

HEROIN/OPIATE & OTHER ANALGESIC USE:

Have you ever used opium, heroin, darvon, darvocet, codeine, Demerol. Etc.? Yes___ No___

(the following are not applicable if the above was answered "no.")

Name of Drug	Age first used	Method of use	Frequency of use	Duration of use	Usual amount consumed	Maximum amount consumed	Date of last use

Have you ever experienced the following with use or after using heroin/opiates?	Yes	No
Cravings for an opioid		
Muscle aches/cramps		
Fever		
Tremors		
Increased heart rate		
Diarrhea		
Yawning		
Nausea/vomiting /loss of appetite		
Papillary dilation		
Goose bumps/sweats		
Rhinorrhea		
Lacrimation		
Stayed high for more that one day		
Used more or for longer periods of time than intended		
Used more to relieve or avoid withdrawal symptoms		
Family problems associated with using		
Problems with your children from using		
Extended family problems from using		
Problems with your friends due to using		
Health problems from using (liver, kidneys, stomach, throat, mouth)		

INHALANT USE:

Have you ever sniffed/inhaled aerosols, lighter fluid, gasoline, model cements, solvents, rush,

White out, glue, paint, etc.? Yes_____ No_____

(the following are not applicable if the above was answered "no.")

Name of Drug	Age first used	Method of use	Frequency of use	Duration of use	Usual amount consumed	Maximum amount consumed	Date of last use

Have you ever experienced the following with use or after using inhalants?	Yes	No
Sleep disturbances		
Shakes/tremors		
Nausea/sweats		
Irritability		
Abdominal discomfort		

Continued for inhalant use:	Yes	No
Chest discomfort		
Being amotivational		
Stayed high for more that one day		
Used more or for longer periods of time than intended		
Used more to relieve or avoid withdrawal symptoms		
Has using created family problems		
Has using created problems with your children		
Has using created problems with your extended family		
Has using created problems with your friends		
Has using created health problems (liver, kidneys, stomach, throat, mouth)		

METHAMPHETAMINE USE:

Have you ever used methamphetamines? Yes____ No____

(the following are not applicable if the above was answered "no.")

Name of Drug	Age first used	Method of use	Frequency of use	Duration of use	Usual amount consumed	Maximum amount consumed	Date of last use

Have you ever experienced the following with use or after using meth?	Yes	No
Depression		
Agitation		
Insomnia/hypersomnia		
Vivid unpleasent dreams		
Anxiety		
Irritability		
Fatigue		
Increased appetite		
Stayed high for more that one day		
Used more or for longer periods of time than intended		
Used more to relieve or avoid withdrawal symptoms		
Family problems from using		
Problems with your children from using		
Extended family problems from using		
Problems with your friends from using		
Health problems from using (liver, kidneys, stomach, throat, mouth)		

NICOTINE USE:

Do You:	Yes	No
Smoke cigarettes/cigars/pipe		
If answered yes—how many packs per day, etc.		
Use smokeless tobacco, if yes how much per day		
Have sores in your mouth		
Ever cough up blood		
Attempted to quit or control your use of nicotine		

STIMULANTS/AMPHETAMINE USE:

Have you ever used speed(ers), white crosses, ephedrine, crank, crystal, uppers? Yes___ No___
 (the following are not applicable if the above was answered “no.”)

Name of Drug	Age first used	Method of use	Frequency of use	Duration of use	Usual amount consumed	Maximum amount consumed	Date of last use

Have you ever experienced the following with use or after using stimulants or amphetamines?	Yes	No
Depression		
Agitation		
Insomnia/hypersomnia		
Vivid unpleasant dreams		
Anxiety		
Irritability		
Fatigue		
Increased appetite		
Stayed high for more that one day		
Used more or for longer periods of time than intended		
Used more to relieve or avoid withdrawal symptoms		
Family problems from using		
Extended family problems from using		
Problems with children from your using		
Problems with your friends from using		
Health problems associated with using (liver, kidneys, throat, mouth, stomach)		

SEDATIVE, HYPNOTIC OR ANXIOLYTIC USE:

Have you ever used a barbiturate, downer, sleeping medication, valium, ativan, zanax, Librium, etc? Yes___ No___

(the following are not applicable if the above was answered “no.”)

Name of Drug	Age first used	Method of use	Frequency of use	Duration of use	Usual amount consumed	Maximum amount consumed	Date of last use

Have you ever experienced the following with use or after using the above mentioned drug?	Yes	No
Anxiety		
Tremors		
Shakiness		
Tingling		
Diarrhea		
Nausea and/or vomiting		
Dizziness		
Agitation		
Insomnia		
Headaches		
Blurred vision		
Seizures		
Muscle aching/twitching		
Concentration difficulties		
Stayed high for more that one day		
Used more or for longer periods of time than intended		
Used more to relieve or avoid withdrawal symptoms		
Using created family problems		
Using created extended family problems		
Using created problems with your children		
Using created problems with your friends		
Using created health problems (liver, kidneys, throat, stomach, mouth)		

PHENCYCLIDINE USE:

Have you ever used PCP, angel dust, ecstasy, etc.? Yes___ No___

(the following are not applicable if the above was answered “no.”)

Name of Drug	Age first used	Method of use	Frequency of use	Duration of use	Usual amount consumed	Maximum amount consumed	Date of last use

OTHER SUBSTANCES, OVER THE COUNTER USE:

Do you use antihistamines, Nytol, Nyquil, No-Doz, laxatives, Primatene, diet pills, Mydol, etc.? Yes___ No___

If yes, explain usage_____

I. V. DRUG USE:

Have you ever used I. V. drugs? Yes_____ No_____

(the following are not applicable if the above was answered "no.")

Name of Drug	Age first used	Method of use	Frequency of use	Duration of use	Usual amount consumed	Maximum amount consumed	Date of last use

GAMBLING HISTORY:

What forms of gambling do you participate in?

	Yes	No		Yes	No
Video Lottery			Slot Machines		
Black Jack			Powerball		
Bingo			Sports		
Scratch Tickets			Pull Tabs		
Poker (cards)			Dog Racing		
Horse Racing			Other(s)		

How much do you spend a month on gambling?_____

How often do you gamble?_____

Do you feel you have a gambling problem? Yes_____ No_____

If yes, how long has it been a problem?_____

When gambling, have you ever:	Yes	No
Gambled longer than you planned		
Gambled the next day to win back your losses		
After winning, gambled away your winnings or part of it		
Tried to quit or control your gambling		
Gotten behind on bills because of gambling		
Went without necessities because of gambling losses		
Written bad checks in order to gamble		
Used credit cards to obtain money to gamble		
Sold or pawned anything to get money for gambling		
Had any legal problems because of your gambling		
Been arrested, spent time in jail or prison because of your gambling		
Felt remorse after gambling		
Felt your gambling affected your relationship with your spouse or significant other		
Felt like you wanted to quit gambling but couldn't		

PHYSICAL AND MEDICAL:

List any health problems: _____

What is your present state of health? _____ excellent _____ good _____ fair _____ poor.

Height: _____ Weight: _____ Color eyes: _____ Color hair: _____

Are you currently under the care of a physician, if so for what? _____

When was the last time you saw a physician and reason for visit? _____

Serious injuries/illnesses in past/present: _____

Surgery/s (List): _____

Identifying Marks(scars/tattoos, etc.): _____

Allergies/physical handicaps/disabilities: _____

Are you free of communicable disease? _____ If no list disease(s): _____
If not sure, have you or do you wish to be tested? _____

Do you have health insurance? _____ If yes, list company _____

GLORY HOUSE MUST HAVE DOCUMENTATION OF A RECENT TUBERCULOSIS (TB) TEST (WITHIN THE PAST 30 DAYS) BEFORE ADMISSION WILL BE CONSIDERED.

LAST TUBERCULOSIS TEST DATE: _____ **RESULTS:** _____

WHAT TREATMENT IS PERSCRIBED: _____

WHERE WAS TB TEST GIVEN (facility/clinic, etc.): _____

I GIVE PERMISSION FOR GLORY HOUSE TO REQUEST RECORDS OF TB TEST. _____

Are you willing to sign a release of information form so Glory House may send for social, medical, or psychiatric/psychological reports? _____ **Yes** _____ **No**

(Separate release of information form must be completed if medical personnel are not able to include written proof of test results)

PSYCHOLOGICAL HISTORY:

Have you ever had any counseling and/or treatment for problems other than substance abuse? _____

If yes, list below:

Facility/Person	Reason for counseling/ Hospitalization	Date

Check all that apply:	Yes	No
Do you feel sad, down and/or depressed		
Do you feel fearful, anxious and/or nervous		
Have you ever had a panic attack		
Do you have feelings of uncontrollable anger, rage or violence		
Do you find yourself being physically abusive to others		
Have you ever been physically abused		
Do you find yourself being sexually abusive to others		
Have you been sexually abused		
Do you have thoughts of harming other people		
Have you ever had thoughts of harming yourself		
Have you made plans for carrying out any of those thoughts		
Have you ever attempted suicide		
Do/did you eat without stopping or without remembering what you were doing		
Do/did you binge on food and then vomit		
Have you lost /gained more than 10 pounds in the last year		
Do/did you have sex with many people you did/didn't know very well		
Are/have you been in a relationship that did/doesn't feel good but couldn't/can't be without it		
Do/did you exercise heavily to get a rush		
Do/did you exercise too hard or too long to the exclusion of other important needs		

EDUCATION:

Do you have high school diploma or GED (circle the one that applies)

If you dropped out: What was last grade attended? _____ Why did you drop out? _____

What were your grades like? _____

How did you get along with your classmates? _____

How did you get along with your teachers? _____
 What problems did you experience when attending school? _____
 How did alcohol and/or drugs interfere with your education? _____
 List any college you have attended. _____

VOCATIONAL:

Are you employed _____ Where? _____

Do you need assistance with finding employment? _____

Work History: list past four jobs, starting with most recent:

Employer	Address	Dates worked	Reason for leaving

In the last three years, how many times have you changed jobs? _____

How many months have you worked during the past year? _____

List job skills and trade: _____

List vocational training, certificates received and where: _____

Did you serve in the military? _____ YES _____ NO List branch, where and dates served: _____

Are you a War veteran? _____ YES _____ NO If yes, list which war: _____

Type/date of discharge: _____

FINANCIAL:

Current source of income: _____ Any income from family/amount: _____

Annual gross income (before taxes) past 12 months _____

If admitted to the Glory House, how will you pay for services? _____

Are you in debt? _____ Amount: _____ Do you have difficulty managing your money? _____

Court ordered to pay restitution? _____ Amount/payable to whom: _____

Court ordered to pay child support? _____ Amount/payable to whom: _____

Are you behind on child or spousal support? _____ Amount: _____

Do you have fines, court costs to pay? _____ Amount/payable to whom: _____

Do you have any unusual financial concerns? _____ Explain: _____

Have You Ever:	Yes	No
Sold alcohol and/or drugs		
Traded things for alcohol and/or drugs		
Pawned things for alcohol and/or drugs		
Borrowed money to buy alcohol and/or drugs		
Went without other things to buy alcohol and/or drugs		
Have you ever stolen alcohol and/or drugs		
Have you used alcohol and/or drugs while on probation/parole		
Have you had probation/parole violated due to alcohol and/or drugs		
Have you ever shoplifted for money to buy alcohol and/or drugs		
Have you ever committed a burglary for alcohol and/or drugs		

LEGAL HISTORY:

Age of first arrest? _____ Charge/s: _____

Have you ever been in a juvenile institution? _____ If yes, list why/where/when: _____

Are you in prison or jail now? _____ If yes, list why/where _____

How many times have you been on state parole/probation? _____ Federal parole/probation? _____

How many convictions have you had in the past five years for all offenses? _____

List all charge/s include dates: _____

If in prison or jail, when is your next parole date? _____

If granted parole, when do you expect to be released? _____

SOCIAL:

Do You Have:	Yes	No
Friends that use alcohol and/or drugs		
Friends that try and talk you <u>into</u> drinking and/or using		
Friends that try to talk you <u>out</u> of drinking and/or using		
Friends that you can trust How many _____		
Any close friends How many _____		
A hard time trusting others		
Less time spent on hobbies, recreation, or leisure activities		
Lost friends due to your alcohol and/or drug use		
Friends you discuss your concerns about your alcohol and/or drug use		
Friends that express concerns about your alcohol and/or drug use		

Do you have any talents or skills? Yes _____ No _____

If yes, what are they? _____

What do you like to do for fun or relaxation (hobbies, sports, art, etc.)? _____

FAMILY:

Father's Name _____ Address _____

Mother's Name _____ Address _____

Foster Mother _____ Address _____

Foster Father _____ Address _____

Number of brothers/ages: _____

Number of sisters/ages: _____

Step/half brothers or sisters/ages: _____

Father's Occupation: _____

Mother's Occupation _____

Were they regularly employed? _____

Were your parents divorced or separated? _____

How old were you when they separated/divorced? _____

How did you get along with your parents/siblings? _____

How were you disciplined as a child? _____

Which family members are supportive of you and your lifestyle changes? _____

Either of your parents deceased, which one, how old were you when they passed away? _____

Have you kept close ties with your family during the past five years? _____ If no, why not? _____

Does anyone in your family have a criminal record? _____ Who? _____

Alcohol abuse in family? Yes No Who? Mother Father other: _____

Drug abuse in family? Yes No Who? Mother Father other: _____

Looking back at your childhood, what caused you the most unhappiness? _____

Did you have any significant problems as a child? _____ If yes, what? _____

Did you ever run away from home? ____ Why/How many times? _____

Living arrangement prior to admission to Glory House. _____

Single: ____ Married: ____ Divorced: ____ Separated: ____ Widowed: ____ Living with significant other: _____

If married, living with (or divorced/separated) answer the following:

Current/most recent partner's name: _____

Relationship (wife, girl/boy friend, etc.) _____

Address: _____

Partner's occupation: _____ How is he/she being supported now? _____

Give brief information about previous marriages/relationships (when married/divorced, etc.):

Name	Dates married/divorced	Reason for divorce/separation

INFORMATION ABOUT CHILDREN:

Which relationship	Name	Age/ Sex	Now living with	Yours/step

SPIRITUAL:

What is your church preference (Baptist, Native American, Methodist, Presbyterian, Catholic, Lutheran, etc.)? _____

When was the last time you attended church? _____

Did you attend as a child? _____ Was attendance required? _____

On an average, how many times per month have you attended church during the last six months? _____

Do you consider yourself to be a religious/spiritual person? _____

List some of your basic religious/spiritual beliefs: _____

	Yes	No
Do you believe in a Higher Power (example God or Tunkashila)		
Do you have any concerns about your spiritual beliefs/practices		
Do you have any religious beliefs		
Lost faith in a Higher Power		
Have you lost dreams/goals		
Are you hopeful about the future		
Have you done things drunk/high you wouldn't if you were sober/straight		
Do you consider yourself to be a spiritual person		
Has there been a change in your religious beliefs		

What things lift your spirit? _____

What are your strengths? _____

What are your weaknesses? _____

What thing would you like to change about yourself? _____

MISCELLANEOUS:

Have you ever stayed in a halfway house before? _____ Where/when/why? _____

Do you have a valid driver's license? _____ List state/license number/expiration date: _____

If revoked, when/why: _____

Do you have a car? _____ If yes, license number/make/model/year? _____

Do you have car insurance? _____ List insurance company, policy number, expiration date: _____

Do you have a copy of your Social Security Card? _____ If not, you need to have a Social Security Card prior to admission as this will be necessary for identification purposes in order to secure employment.

GLORY HOUSE GUIDELINES

The following guidelines must be followed while you are a resident of Glory House. Individuals who disregard these guidelines are sanctioned according to the Sanction Levels as stated the Sanction Level document which also lists consequences if guidelines are not followed. Further clarifications of Glory House guidelines are in the Resident Handbook that you will receive upon admission.

1. During the first 14 days, residents will be restricted to the Glory House property except for work and program requirements. After the restriction period (which can be extended if sanctions are received), residents are required to be at Glory House and programming at all scheduled times.
2. While at Glory House, residents are expected to be employed full time in order to meet financial obligations, but not to the exclusion of programming.
3. Use of alcohol or drugs or presence in alcohol related establishments is not permitted.
4. Residents are expected to respect other people and property at Glory House and in the community.
5. Food and beverages are only allowed in designated eating areas, (mainly the dining room and outside the facility).
6. Residents are required to punch out, using the time clock, any time when leaving Glory House property, and to punch in upon return. A staff member must initial the time card in resident's presence.
7. Any form of physical contact or other forms of conning, manipulation or intimidation may be grounds for immediate removal from the program.
8. Residents are responsible to follow the Glory House Resident Handbook and agree to do so.

AGREEMENT TO COOPERATE WITH GLORY HOUSE PROGRAM

As a resident of the Glory House, I will comply with the Glory House guidelines, which are in effect or which may be brought into effect at a later date. I agree to participate in treatment programs, which are prescribed for me. If unemployed, I will diligently seek employment. I understand paying room and board (or rent) is my first financial obligation. I will voluntarily sign an assignment of my wages to Glory House. I understand that failure to comply with any of the Glory House Guidelines will subject me to restriction, and possible expulsion from Glory House. I understand that the Glory House does not provide medical services and any and all medical expenses incurred by me will be paid by me. I will not hold Glory House or its' employees or its' Board of Directors liable for any injury or damage, or loss by reason of any act arising out of my stay at Glory House.

In the event I violate the law, bond requirements, conditions of my placement as stipulated by referring officials, i.e., state or federal prison requirements, state or federal probation or parole requirements, and/or Glory House Guidelines, I hereby agree that Glory House officials may release information concerning me to these various authorities as it may pertain or are directly connected with my placement at Glory House. Glory House has the right to collect money owed to the facility and may need to release the client's name and last address in collection of any debt.

I _____, certify that I have read or had explained to me the Glory House Guidelines, and I understand and will abide by them, and that I will participate in a full program of group and individual counseling and treatment, including programs listed on my treatment plan.

APPLICANT SIGNATURE

Date

WITNESS SIGNATURE:

Date

Signature of Glory House staff reviewing application

Date

Revised: 6/95
Revised: 10/02
Revised: 3/04

APPLIC.DOC

DISPOSITION OF PROPERTY FOR _____
(print - last name then first name please)

My personal property including but not limited to automobiles left by me at Glory House should be released to the following person upon proof of identification. (photo ID)

Name _____
 Address _____
 City _____ State _____ Zip _____
 Telephone (____) _____

It is my understanding and I agree that if my property is not claimed within ten (10) days of my leaving Glory House that Glory House may dispose of the property in any method deemed appropriate.

_____ Date _____ Date _____
 Client Signature Staff Signature

SEIZURE OF PROPERTY

The personal property has been removed from clients room No _____ and transferred temporarily to _____ because _____ (give reason.)

by _____ Date _____ Date _____
 Staff Signature Staff Signature

The personal property has been inventoried (list attached to each parcel) and transferred to the garage storage

by _____ Date _____ Date _____
 Staff Signature Staff Signature

The personal property has been disposed of in the following manner _____.

by _____ Date _____ Date _____
 Staff Signature Staff Signature

Place this form and the original inventory list(s) in the supervisor's area until removed from Glory House.
 There are _____ (number) of parcels in storage.

RELEASE OF PROPERTY TO AUTHORIZED PERSON

The personal property has been released to (copy of photo ID attached)

_____ Date _____
 Print Name Signature

by _____ Date _____
 Staff Signature

PERSONAL REMOVAL

I have personally removed all of my personal property.

_____ Date _____
 Client Signature

_____ Date _____
 Staff Signature