APPLICATION FORM

Mail to: Trinity Life Ministry, 2150 Elmwood Ave., Lafayette, IN 47904

Phone: 765-742-1060 Fax: 765-742-1061

If spaces are left blank or less than honest information is provided, your application will not be placed into consideration for entry into the program. Completion and submission of this application does not guarantee admission, nor does it guarantee being given an intake interview or assessment. However, you will be contacted after a review of the application is complete, and a determination is made on possible consideration for entry.

Today's date:					
PERSONAL HISTORY					
Last name:	First:	Middle:		Marital status (circle one) Single / Mar / Div / Sep / Wid	
Address:				Contact phone no.: ( )	
City:		State:		ZIP Code:	
Birth date: / /	Age:	Sex: ❑ M ❑ F	Race:	Children:	
Have you ever been homeless? ❑ Yes ❑ No					

EMPLOYMENT / EDUCATION	
Highest Level of Education Successfully Completed:	GED : ❑ Yes ❑ No
Schools or Programs Attended and Completed:	
Present Employer:	Supervisor's Name:
Address:	Have you ever served in the Military? ❑ Yes ❑ No
Phone:	

SUBSTANCE USE					
Alcohol Abuse: ❑ Yes ❑ No	If yes, last date of use: / /				
	Type(s) of Alcohol preferred:				
Drug Abuse: ❑ Yes ❑ No	If yes, last date of use: / /				
	Type(s) of Drug preferred:				
Have you been in a treatment program previously?: ❑ Yes ❑ No			If yes, When?		
			If yes, Where?		
Length of Program:			Did you complete the Program:		
Have you ever been suicidal or had suicidal thoughts?			Have you ever overdosed?		
Age of 1st use of:					
Alcohol	Marijuana	Cocaine	Smoking	Opiates	Amphetamines
PCP	Hallucinogens	Sedatives	Inhalants	Prescription Drugs	OTC Drugs

Spiritual Background

Church currently attending or last attended:

Address:

Pastor's Name:

16 Week / Developing Work Ethic Class:

Part of our Transformation Phase curriculum is doing actual on-the-job training, helping you create a "resume for success" for future employment, leadership and skill development. Your signature will enroll you in this important facet of our transformation program.

Signature:

If you have a disability and can't work you must provide documented proof of disability.

LEGAL

What legally prescribed medications are you currently taking?

Are you currently incarcerated?	If yes, which county?
❑ Yes ❑ No	What are your charges?
Hearing Date:	What is your legal status?
/ /	Type of hearing? Initial / Sentencing / Other
Attorney:	Phone Number: ( ) - -
Prosecutor:	Judge:
Are you currently on Probation?	Probation Officer's Name:
❑ Yes ❑ No	Could you be court ordered into this program?
Are other charges pending in any other location?	If yes, what charges and in what county?
❑ Yes ❑ No	List all locations in which you are on probation, if any.

FAMILY CONTACT INFORMATION

In case of emergency whom should we contact, if accepted?	Relationship:	Home phone no.:	Work phone no.:
		( )	( )

I understand that signing this application allows the staff of Trinity Life Ministry to verify all statements and representations made on this application and further understand that making false statements will cause the application from being considered. If accepted and false or misleading statement are discovered on this application or during the consideration process it will constitute cause for immediate discharge from the program.

By signing this program application, I understand that my acceptance into this program will be determined by my actions, honesty and cooperation during the interviewing process. I agree to allow the testing of breath samples for alcohol use and urine testing for drugs use, if the staff deems in necessary. I understand that the refusal to submit to the testing for use of alcohol and drugs is an admission of use and I will be possibly discharged from Trinity Life Ministry, if accepted, as a result of that refusal. I also agree to sign all releases, if accepted.

Print Name:

Signature *Date*

Completing this form DOES NOT GUARANTEE acceptance into this program. False statements, half-truths and misleading information will result in disqualification. This information will be verified.

What friends or family members would benefit receiving spiritual support as you battle with your addictions:

Name	Relationship	Phone#	Email