

## APPLICATION FOR ADMISSION

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All applicants must complete this application. Falsifying any of the information will be grounds for termination of the application process.

APPLICANT INFORMATION					
Applicant Name:		DOB:			
CONTACT INFORMATION					
Email Address:					
Home Phone:		Cell Phone:			
Street Address:					
Mailing Address:					
City:		State:		Zip Code:	

## GENERAL INFORMATION

How did you hear about Youth-Reach Gulf Coast?

- Internet Search
- Social Media
- Flyer/Brochure
- Friend
- Other

Are you aware that we are a Christ-centered home?

- Yes
- No

We believe that our only hope is freedom in Christ. Would you be open to exploring a true relationship with Jesus Christ, understanding that it may look different than church as you've known it?

- Yes
- No



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List the locations (cities) you have lived in for the past three years.

- 1.
- 2.
- 3.

How would you rate your attitude towards submitting to authority?

- Excellent  
 Fair  
 Poor

Please describe what your attitude towards submitting to authority has been recently.

Are you currently involved in a committed relationship (i.e. girlfriend, fiancée, wife, etc.)?

- Yes  
 No

Do you currently have or support children?

- Yes  
 No

During the last 12 months, how often did you have any kind of drink containing alcohol?

- Every Day  
 5-6 Times Per Week  
 3-4 Times Per Week  
 Twice Per Week  
 Once Per Week  
 2-3 Times Per Month  
 Once Per Month  
 3 to 11 Times in the Past Year



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- 1 or 2 Times in the Past Year
- Never

Do you or have you ever used recreational drugs?

- Yes
- No

If you answered yes to the above question, please explain which drugs you have used, what age you began using drugs, and how often you have used drugs in the past 6 months.

## CRIMINAL HISTORY

Have you ever been charged with or convicted of a crime?

- Yes
- No

If you answered yes to the above question, please list all charges even if you have completed your time or probation.

Have you ever been accused or convicted of a sexual offense?

- Yes
- No

If you answered yes to the above question, please explain.



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Do you presently have a criminal record?

- Yes  
 No

Are you currently on probation or parole?

- Yes  
 No

If you answered yes to the above question, please explain the offense(s) and explain the details of your probation.

Do you have any upcoming court dates?

- Yes  
 No

If you answered yes to the above question, please list the location(s), date(s)/time(s) and charge(s).

## PREVIOUS PROGRAMS

Please enter all of the information below for any other long-term stay facilities you have attended.

Have you ever participated in a long-term residential program?



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- Yes  
 No

Facility #1					
Facility/Program Name:					
Reason for Admittance :					
Reason for Termination & Result:					
Date of Entry:		Date of Termination:			
Street Address:					
Mailing Address:					
City:		State:		Zip Code:	

Facility #2					
Facility/Program Name:					
Reason for Admittance :					
Reason for Termination & Result:					
Date of Entry:		Date of Termination:			
Street Address:					
Mailing Address:					
City:		State:		Zip Code:	

## FAMILY RELATIONSHIPS


FATHER'S CONTACT INFORMATION	
Father's Name	
Father's Occupation:	



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Email Address:				
Home Phone:		Cell Phone:		
Street Address:				
Mailing Address:				
City:		State:		Zip Code:

MOTHER'S CONTACT INFORMATION				
Mother's Name				
Mother's Occupation:				
Email Address:				
Home Phone:		Cell Phone:		
Street Address:				
Mailing Address:				
City:		State:		Zip Code:

Are your parents divorced?

- Yes  
 No

If your parents are divorced, are either of them remarried?

- Yes  
 No

How would you rate your relationship with your parents?

- Excellent  
 Fair  
 Poor

Please explain why you selected the above rating to describe your relationship with your parents.

**SIBLING INFORMATION**

SIBLING #1 CONTACT INFORMATION			
Sibling Name:			
Date of Birth:		Phone:	

SIBLING #2 CONTACT INFORMATION			
Sibling Name:			
Date of Birth:		Phone:	


SIBLING #3 CONTACT INFORMATION			
Sibling Name:			
Date of Birth:		Phone:	

How would you rate your relationship with your siblings (brothers/sisters)?

- Excellent
- Fair
- Poor

Please explain why you selected the above rating to describe your relationship with your siblings.


**REFERENCES**



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Please list information for at least one references (e.g. relative, friend, teacher, etc.) we can contact. Additional references may be requested during the interview process.

REFERENCE #1 CONTACT INFORMATION			
Reference Name:			
Occupation:			
Age:		Phone:	

REFERENCE #2 CONTACT INFORMATION			
Reference Name:			
Occupation:			
Age:		Phone:	

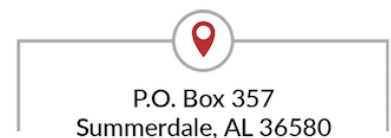
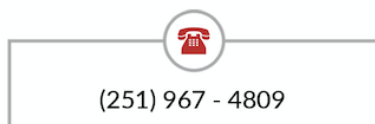
REFERENCE #3 CONTACT INFORMATION			
Reference Name:			
Occupation:			
Age:		Phone:	

## EDUCATIONAL BACKGROUND

LAST SCHOOL ATTENDED					
School Name					
Last Grade Completed:					
Street Address:					
Mailing Address:					
City:		State:		Zip Code:	

## FORMS OF IDENTIFICATION

Do you have a copy of your birth certificate?





- Yes
- No

Please select the forms of ID you have in your possession.\*

- Driver's License
- Social Security Card
- State Issued ID
- None of These
- Medical History

## MEDICAL HISTORY

Please note that residents are responsible for all medical bills while in residence at Youth-Reach Gulf Coast. Have you ever been diagnosed with any of the following medical conditions?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Rubella<br><input type="checkbox"/> Measles<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> HIV<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Tumor<br><input type="checkbox"/> Hernia<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bronchitis<br><input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chicken Pox<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Vision Loss<br><input type="checkbox"/> Hearing Loss<br><input type="checkbox"/> Stomach Ulcers<br><input type="checkbox"/> A.I.D.S.<br><input type="checkbox"/> Kidney Infection<br><input type="checkbox"/> Venereal Disease<br><input type="checkbox"/> Major Surgery<br><input type="checkbox"/> Psychiatric Issues<br><input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Diabetes<br><input type="checkbox"/> Enlarged Heart<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Eating Disorders<br><input type="checkbox"/> Thyroid Dysfunction<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Migraines<br><input type="checkbox"/> Seizures<br><input type="checkbox"/> Other |
|--|---|--|

## PHYSICIAN INFORMATION

PHYSICIAN CONTACT INFORMATION	
Physician Name:	
Phone:	
Street Address:	
Mailing Address:	



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City:		State:		Zip Code:	
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Date of Last Medical Exam:

Date of Last Dental Exam:

Do you have any physical disabilities?

- Yes  
 No

If you answered yes to the question above, please explain.

Have you ever sought psychological or psychiatric help?

- Yes  
 No

Please select the following issues you have received counseling or treatment for.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Drugs               | <input type="checkbox"/> Homosexuality      | <input type="checkbox"/> Manipulation               |
| <input type="checkbox"/> Alcohol             | <input type="checkbox"/> Anger/Rage         | <input type="checkbox"/> Stealing                   |
| <input type="checkbox"/> Emotional Stability | <input type="checkbox"/> Bipolar Disorder   | <input type="checkbox"/> Lying                      |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Violent Tendencies | <input type="checkbox"/> Attention Deficit Disorder |
| <input type="checkbox"/> Pornography         | <input type="checkbox"/> Motivation         | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Sexual Perversion   | <input type="checkbox"/> Suicidal Thoughts  |   |

**THERAPIST INFORMATION**  
*(If Applicable)*

**THERAPIST CONTACT INFORMATION**

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Therapist Name:					
Phone:					
Street Address:					
Mailing Address:					
City:		State:		Zip Code:	

Are you currently taking any medication?

- Yes  
 No

If you answered yes to the question above, please list all medications and dosages.

Are you allergic to any medications?

- Yes  
 No

If you answered yes to the question above, please list all medicine allergies.

## RESIDENT STATEMENT OF AGREEMENT

By submitting this application for admission, I am agreeing to live by all requirements of residency at Youth-Reach Gulf Coast for the duration of my stay. I also understand that repeatedly breaking these established rules will result in my immediate termination from this Christ-centered home. I give permission to the staff of Youth-Reach Gulf Coast to hold me accountable to resident standards.



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## APPLICATION FOR ADMISSION SUBMISSION

Signatures below indicate authorization of all pages of this document.

Date:	
Printed Name of Applicant:	
Signature of Applicant:	



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