

WABASH VALLEY TEEN CHALLENGE

STUDENT APPLICATION FOR PROGRAM ENTRY

ENTRANCE REQUIREMENTS

- Requirements are listed in the WVTC Entrance Requirements document. It must be read and signed prior to the phone interview, intake and must be turned in upon arrival.
- Please call during office hours 9am-5pm M-F if you have any questions about the application process or any of the requirements. We are happy to serve you and your family!

PERSONAL DATA AND INFORMATION

Date: _____

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (____) _____ Work: (____) _____

Weight: _____ Height: _____ Hair Color: _____ Eye Color: _____

Social Security Number: _____ - _____ - _____ Birth Date: _____ Age: _____

Sex: Male Female Drivers License Number: _____

State: _____ Drivers License: Valid Expired Suspended Never applied

If suspended, why? _____

In case of an emergency, contact: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (____) _____ Work: (____) _____

Relationship: _____

WHO HAS REFERRED YOU TO TEEN CHALLENGE:

Name: _____

Address: _____
(Street) (City) (State) (Zip)

Phone number: (____) _____ Relationship: _____

RACE/ETHNIC BACKGROUND (Please check only one)

Caucasian Japanese Haitian Puerto Rican Cuban Filipino

African American Chinese Asian American Indian Other

Are you an American Citizen? Yes Native Naturalized No

Explain: _____

PERSONALITY INFORMATION:

Is it easy for you to express your feelings? Yes No Sometimes

Explain: _____

Do you enjoy being with other people, or would you rather be alone?

Explain: _____

PERSONAL FAMILY HISTORY

List parent/parenting figures, spouse, girlfriend, brothers & sisters (do not include your children)

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>AGE</u>	<u>RESIDENCE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Use the back of this page if additional space is required.)

Check the word that best describes your relationship with your parents as a child and now:

	Child	Now
Very Good	<input type="checkbox"/>	<input type="checkbox"/>
Good	<input type="checkbox"/>	<input type="checkbox"/>
Average	<input type="checkbox"/>	<input type="checkbox"/>
Fair	<input type="checkbox"/>	<input type="checkbox"/>
Poor	<input type="checkbox"/>	<input type="checkbox"/>

Are your parents still living? Father: Yes No Mother: Yes No

Are you adopted? Yes No

Were you raised by anyone other than your biological parents? Yes No

if yes, please explain:

When did you last see your parents? _____

When did you last live at home? _____

Occupation- Father: _____ Mother: _____

Parent's marital status: Married Divorced Separated Remarried Living together

If married, how long? _____ If other, how long? _____

How would you rate their marriage? Very happy Happy Average Unhappy

How would you rate your childhood? Good Fair Poor Why? _____

Growing up, whom did you feel closest to? Father Mother Other _____

MARITAL/INTIMATE RELATIONSHIP HISTORY

Marital status: Single Married Separated Divorced Remarried Widowed

List your present living arrangement: *(Please check all that apply)*

Living alone With Parents With Spouse With others (non-relatives)

With others (relatives, including children) Other: _____

If you are, or have been married, please list: (Start with your most recent marriage.)

PERSON MARRIED TO MONTH/YEAR ENDED IN MONTH/YEAR

(Divorce, Separation, Death)

Current spouse (full name) _____

Address: _____

(Street)

(City)

(State)

(Zip)

Home Phone: (____) _____ Work: (____) _____

Do you have any children? Yes No If yes, please list:

NAME OF CHILD AGE WHERE LIVING

(Use back of this page if additional space is required.)

Describe any positive or negative aspects of your relationship with your children:

Describe any problems or concerns related to your relationship with your spouse or girl/boyfriend:

Have you been physically abused? Yes No

Have you been emotionally abused? Yes No

Have you been sexually abused? Yes No

To your knowledge, has anyone in your family ever been sexually abused? Yes No

When: _____ Who: _____

When: _____ Who: _____

Sexual Lifestyle: *(Please check all that apply)* Bisexual Heterosexual Homosexual

Pornography Prostitution

Any recently involved? _____

Have you ever engaged in homosexual activities? Yes No

MILITARY SERVICE HISTORY

Have you ever served in the U.S. Armed Forces? Yes No

If yes, describe: Branch of Service: _____

Date of Entry: _____ Date of Discharge: _____

Military occupation standing (MOS): _____

Rank attained: _____

Discharge received: Honorable Less than Honorable Dishonorable

Eligible for V.A. medical benefits? Yes No Unknown

LEGAL HISTORY

Are you legally mandated to participate in a Teen Challenge-type program? Yes No

If yes, by whom? Parole Board Court Other (explain): _____

If answer is Court, Please list county of origin: _____

Are you currently or will you be under legal supervision? Yes No

Are you or will you be under house arrest / require ankle bracelet? Yes No

Method of reporting: Phone Letter In person (explain): _____

How often do you report? _____ How long? _____ Time remaining? _____

Probation or Parole Officer's Name: _____

Agency: _____ Phone Number: _____

Address: _____

(Street)

(City)

(State)

(Zip)

Are any of the following pending against you? *(Please check those that apply)*

Arrest warrant Court appearance Criminal charges Sentencing Other (explain)

If you have checked any of the above, please explain: _____

(Use the back of this page if additional space is required)

Jail or Prison Information:

DATE(S)

INSTITUTION

List all arrests and convictions

<u>Date</u>	<u>Charges</u>	<u>Conviction (Y/N)</u>	<u>Sentence</u>	<u>Time in Jail</u>	<u>Drug related?</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

(Use the back of this page if additional space is required.)

SOCIAL INVOLVEMENT HISTORY

Describe your involvement in the following:

Religion: _____

Recreation/Sports: _____

Peer Groups: _____

Community affiliations: _____

Hobbies: _____

Other: _____

FINACIAL

If you enter our program, what provisions will be made for the following expenses?

Medical? _____

Dental? _____

Are you eligible for and/or receiving the following: Welfare Disability payments
Unemployment comp. Workman’s comp. Other income (explain next page)

Have you ever applied for food stamps? Yes No Where? _____

Do you have any outstanding debts? Yes No Explain: _____

<u>Owed to</u>	<u>Amount</u>	<u>Address</u>	<u>Phone</u>	<u>Payment</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SIGNIFICANT LIFE EVENTS

Describe any of the following that you are experiencing or have recently experienced:

Moves: _____

Losses (personal, financial): _____

Neglect: _____

Foster home placement or institutionalization: _____

Ethnic/cultural influences: _____

Other (specify): _____

(Use the back of this page if additional space is required.)

ACADEMIC HISTORY

List the highest grade that you have completed: _____

Do you have your High school diploma Yes No *If No, do you have your GED* Yes No

Are you currently in an education program? Yes No

If yes, list: _____

(Name of Program)

(City)

If you are no longer in an education program, please explain your reason for leaving school:

Are you receiving or have you received vocational training? Yes No

If yes, list: _____

TYPE OF TRADE

DATE OF TRAINING

CERTIFICATE ISSUED

OR SKILLS

(Mo/Yr) to (Mo/Yr)

Yes or No

_____	_____	_____
_____	_____	_____
_____	_____	_____

Can you read? Yes No Good Average Poor

Can you write? Yes No Good Average Poor

Describe your future educational and vocational training goals and plans:

Educational: _____

Vocational: _____

OCCUPATIONAL HISTORY

What is your vocational trade or profession, if any? _____

How many jobs have you held in the last two years? _____

List your present employment status:

- Unemployment (*Have not sought employment in the last 30 days*)
- Unemployment (*Have sought employment in the last 30 days*)
- Employed part-time (*Working less than 35 hours per week*)
- Employed full-time (*Working 35 hours or more per week*)

List your two most recent jobs? (*Start with your most recent job*)

(Name of Employer) _____ (Position Held) _____

(Employed from - Mo/Yr to Mo/Yr) _____ (Reason for leaving) _____

(Name of Employer) _____ (Position Held) _____

(Employed from - Mo/Yr to Mo/Yr) _____ (Reason for leaving) _____

List your current average monthly income: _____

Describe your primary source of income: _____

How will you pay for the program? _____

Describe your future occupational goals and plans: _____

Skills: _____

Have you ever experienced or presently have a physical ailment, injury, or handicap that would prevent you from performing manual work-related tasks while enrolled in Teen Challenge?

Yes No If yes, please explain: _____

PSYCHOLOGICAL HISTORY

Have you ever received mental health treatment? Yes No If yes, please list:

<u>Date</u>	<u>Name of Clinic</u>	<u>Reason for Mental Health Treatment</u>	<u>Outcome</u>
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(Use the back of this page if additional space is required)

Has a family member or someone close to you ever attempted or committed suicide? Yes No

Have you ever thought about committing suicide? Yes No

Are you currently thinking about committing suicide? Yes No

Have you ever received psychiatric care? Yes No

If yes, please explain: _____

Will you, as a student of Teen Challenge, be willing to authorize doctors or agencies involved in previous treatments to release your medical records? Yes No

INSURANCE INFORMATION

List your health insurance type: *(Please check)*

- No health insurance Other private insurance Blue Cross/Blue
Medicaid/Medicare Other public funds _____

Insurance policy number: _____

Company: _____ Phone: _____

PERSONAL/FAMILY MEDICAL HISTORY

Please check the appropriate box for any family member that has experienced any of the following problems:

	<u>Grandpt</u>	<u>Father</u>	<u>Mother</u>	<u>Spouse</u>	<u>Brother</u>	<u>Sister</u>	<u>Child</u>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe any illness and developmental problem/concern you experienced as a child:

Do you have any special diet requirements? Yes No

If yes, please explain: _____

When were your teeth last examined? _____

Are you currently experiencing problems with your teeth? Yes No

If yes, please explain: _____

If you drink coffee, tea, or smoke cigarettes, pleas list the amount you consume each day:

Cigarettes: _____ packs smoked per day.

Coffee: _____ cups consumed per day.

Tea: _____ cups consumed per day.

List how often you used the following drugs.

(Never, Once, Several times, or Regularly)

Alcohol_____	Glue_____
Barbiturates(downers) _____	Tobacco_____
Amphetamines(upper) _____	Meth_____
Heroin_____	Crack_____
Cocaine_____	Marijuana_____
Hallucinogenics _____	K2,Spice, etc._____
Opiates_____	other (specify)_____

List any drugs that you are currently abusing: _____

List your present physician's name: _____

Address: _____

(Street)

(City)

(State)

(Zip)

Phone number: _____

List All Current Medications that you are prescribed:

NAME	DOSAGE	DOCTOR
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPIRITUAL HISTORY

Are you born again? Yes No Date: _____ Place: _____

What is your current spiritual condition? _____

What were the circumstances that led to this? _____

Denominational preference? _____

How often do you attend church? Never Occasionally Regularly

Are you a member of any Church or Religion? Yes No Which one? _____

How often did you attend church as a child? _____

Which Denomination was it? _____

How old were you when you stopped attending? _____

Why did you stop attending? _____

Do you believe in God? Yes No Uncertain

Do you pray? Never Occasionally Often

How often do you read the Bible? Never Occasionally Often

Do you read books of other religions instead of the Bible? Never Occasionally Often

Which ones? _____

What recent changes have you had in your religious life (if any)? _____

Have you ever been involved in cults, such as Christian Science, Jehovah's Witness, Mormonism, Scientology, TM, Eastern Religions, or others? Explain: _____

THE PROBLEM

What is your main problem, as you see it?

What have you done about it?

What are your greatest needs in order of priority?

Have you ever been in a program before? _____

Was it religious or non-religious? _____

How many programs have you been in before? _____

List program name 1: _____

Dates: _____ Reasons for leaving: _____

List program name 2: _____

City/State: _____

Dates: _____ Reasons for leaving: _____

(use the back of this page if additional space is required)

Have you ever been in a Teen Challenge program before? Yes No

When? _____ Where? _____

Why did you leave the program?

Dismissed by staff Left on own Completed the program Graduated N/A

Other _____

Why do you wish to be admitted? _____

What are you expecting (believing) God to do in your life through the program? _____

Describe what you are willing to do, or what you think is required of you: _____

What would you like to do after you leave Teen Challenge? _____

The undersigned student applicant fully acknowledges that the information provided herein is accurate and true to the best of his or her knowledge, and that the applicant form has been completed and filled out by student applicant in his or her own handwriting. Student applicant further understands that any false or incomplete information may cause and result in disqualification from admittance into the program, whether a student is just entering into or is in fact in the program.

(Student Applicant)

(Date)

If the enclosed application form has been completed or filled out by anyone other than student applicant, please provide the following:

1. Name of person completing and filling out application form:

(Name)

(Date)

2. Relationship to applicant: _____

3. Explain why student applicant was unable to complete or fill out the enclosed application form:
