THE WELLS CENTER INC.
FOR WOMEN IN TRANSITION

Applicant Intake Form

All questions must be fully completed or no intake interview will be granted.

Date of Application: _____

Name of Applicant:_____

Marital Status: Married ☐ Single ☐ Divorced/Separated ☐

Spouse's Name:_____

Name of Present Institution or where most recently incarcerated :_____

Current Address: Street:_____

City:_____State:_____Zip:_____

Phone #:_____

Date of Birth: _____ Spouses Date of Birth: _____

Emergency Contact:

Name:_____Relationship:_____

Address:_____

City:_____Zip:_____Phone:_____

Personal History

Education History

Highest grade level achieved: _____ School Name: _____

Did you graduate from High School? ☐ Yes ☐ No Year: _____

If you did not graduate, did you receive a GED? ☐ Yes ☐ No Year: _____

Did you attend college or a trade school? ☐ Yes ☐ No What did you study? _____

Favorite subjects in school?_____
Hobbies:_____

Family Information

At what age did you move from your parent's home?_____

Do you have any children? □ Yes □ No If Yes, what are their ages _____

With Whom and where were your children while you were incarcerated?_____

Address:_____Phone:_____

Transportation Information

Do you own a car? □ Yes □ No Year/Make/Model:_____

Tag Number:_____ State of Registration: _____ Are Tags Current? □ Yes □ No

Driver's License #: _____ State: _____ Is License Current? □ Yes □ No

Drug History

Present alcohol use? □ Yes □ No

Do you smoke? □ Yes □ No Present drug use? □ Yes □ No

Drug(s) of choice? _____

List past drug use:

SUBSTANCE	LENGTH OF USE	TIME PERIOD	QUANTITY

Have you ever attended a drug rehabilitation center? □ Yes □ No (Include programs while incarcerated)

Is yes, when:_____ Where?_____

Have you smoked cigarettes in the last 10 years? □ Yes □ No Do you currently smoke? □ Yes □ No

In the past 10 years, have you (check all that apply):

_____Sought or received advice or treatment for the use of alcohol or drugs?

_____Used cocaine, heroin, or any other narcotic drug except as legally prescribed by a physician?

_____Been treated for psychological or emotional problems with or without medication? Where and when?_____
What is the current status of your condition? _____

Are you currently on Medications?_____ What?_____

Current Situation

What is the reason for your current situation?_____

_____

Employment Background

Most current place of employment:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Job Title:_____ Pay Rate:_____

Duties:_____

Special Skills:_____

Dates of employment:_____ to _____Pay Schedule: ☐ Weekly ☐ Bi-weekly ☐ Monthly

Reason for leaving:_____

What vocational training have you received? _____

List any courses taken in prison: _____

List all machines, equipment, and/or tools you have experience using:_____

_____

Employment information for the last five years including prison jobs:

DATES		NAME OF COMPANY	JOB TITLE & DUTIES
From	To		
From	To		
From	To		
From	To		
From	To		

Criminal Background

List all convictions with the most current first:

DATE	CHARGE	SENTENCE	TIME SERVED

If on **parole**, what is your parole plan?_____

_____

If on **probation**, what are the conditions? _____

Are there any warrants out for your arrest? ☐ Yes ☐ No What county(ies)? _____ Oustanding tickets? _____

If yes, please explain:_____

_____

Probation/Parole Officer:_____ Phone: _____

Medical History

What is the state of your physical/mental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Declining

Do you have any physical or mental handicaps? ☐ Yes ☐ No

If yes, what is your handicap? _____

List all current medications, doses taken, how often and reasons for taking them:_____

_____

_____

In the past 5 years:

Has any physician, psychiatrist, or other medical practitioner examined, advised, or treated you?

☐ Yes ☐ No If yes, what were the circumstances? _____

_____

Have you been a patient in a hospital, clinic, medical or mental health facility/program? ☐ Yes ☐ No

If yes, please explain:_____

Have you ever been committed to a psychiatric hospital? ☐ Yes ☐ No When? _____ Where? _____

Have you been advised to have any test or surgery which was not completed? ☐ Yes ☐ No

If yes, please explain:_____

_____

Do you have a family history of diabetes, cancer, lung disease , heart disease, kidney disease, mental illness or suicide? ☐ Yes ☐ No
(If yes, please circle all that apply)

In the past ten years, have you had any medical diagnosis or received medical treatment for Acquired Immune Deficiency Syndrome (AIDS) or any AIDS related complex (ARC), HIV or any disorder of the immune system? ☐ Yes ☐ No

If yes, please explain:_____

_____

Religious Background

Please explain your religious upbringing:_____

_____

Are you currently or have you ever been a church member? ☐ Yes ☐ No When/Where? _____

If yes, what denomination?_____ Do you consider yourself a Christian? ☐ Yes ☐ No

How does your faith show in the life you lead? _____

_____

_____

What religious activities/programs have you participated in while incarcerated? _____

_____

_____

***Are you referred by Drug Court, Mental Health Court, or Probation? _____Yes ____No**

If so who is the referring Judge/Probation Officer? _____

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"CATCH" COMMUNITY POST-RELEASE Program RULES/Requirement(S)

1. Must be at least 18-years of age
2. Must be a female offender
3. Must reside in Forsyth County, NC
4. Complete Intake Application
5. Agree to complete program requirements (90-days; 120-Days; 1-year; 2-years)
6. Referred by Judge or probation
7. Previously released from Jail or Prison
8. Agree to random drug testing
9. Attend all required classes
10. Participant in Group Sessions
11. Participant in Individual Counseling
12. Have a willingness to change
13. Be patient with yourself
14. No profanity
15. **Cell phone(s) prohibited during class

By Signing, you agree to the following rules and requirements

Signature:_____Date:_____

Monday, July 20, 2020

COVID-19 Liability Waiver

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.
I further acknowledge that THE WELLS CENTER, INC. has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.
I further acknowledge that THE WELLS CENTER, INC. can not guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, staff, and other Clients.
I voluntarily seek services provided by THE WELLS CENTER, INC. and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending the program.
I attest that:
* I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
* I have not traveled internationally within the last 14 days.
* I have not traveled to a highly impacted area within the United States of America in the last 14 days.
* I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
* I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non contagious by state or local public health authorities.
* I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.
I hereby release and agree to hold THE WELLS CENTER, INC. harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the organization, or that may otherwise arise in any way in connection with any services received from THE WELLS CENTER, INC. I understand that this release discharges THE WELLS CENTER, INC. from any liability or claim that I, my heirs, or any personal representatives may have against the organization with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from THE WELLS CENTER, INC. This liability waiver and release extends to the organization together with all owners, partners, and employees.

Client Signature:_____ Date:_____

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RELEASE/EXCHANGE OF CLIENT INFORMATION

I,_____hereby authorize THE WELLS CENTER, INC., to release information contained in my client records to the following individual(s) and/or organization, and only under the conditions listed below:

1. Name of person(s), organization, and address to whom release/exchange is to be made:

   _____ _____

   _____ _____

   _____ _____

2. The specific type of information to be released/exchanged: (Check all that apply)

   ____Diagnosis ___Drug/Alcohol History __Treatment Summary

   ____Assessment ___HIV/TB Test Results

3. The purpose and need for such release/exchange:
   ____Continuity of Treatment

   ____Aftercare Planning

   ____Referral

   ____ Other _____

4. **THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME.** IF NOT PREVIOUSLY REVOKED THIS CONSENT WILL TERMINATE UPON:

   Date: _____

   Client Signature: _____Date: _____

   Witness: _____Date: _____

Created: 07/2020