Warrior Discipleship Ministry Program Application

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APPLICATION – WARRIOR DISCIPLESHIP MINISTRY

Thank you for your interest in the Warrior Discipleship Ministry. Our program is designed to help people struggling with various strongholds and other life controlling problems who desire a faith-based approach to recovery.

To complete the admissions process you must complete the following steps:
1. Complete the attached application online or mail it to the location to which you are applying with all other documents in this packet.
2. Voluntary Compliance with Faith Based Activities Document.
3. Release of Confidential Information Form.

Warrior Discipleship Ministry of North Mississippi
PO Box 706
Senatobia, MS 38668
Attention: Admissions Department
PHONE: 662-526-0958

Upon receipt of your application, an admissions representative will contact you and begin processing your application. The length of the application process can vary from a couple of days to two weeks. In processing an application a number of things are taken into consideration including: mental health, medical condition, past and present legal status, funding eligibility, and a level of care required.

Warrior Discipleship Ministry is a voluntary program. Please carefully review all of the information in this packet to determine if our program is right for you. If not, please contact our admissions office to request a referral list of other recovery programs.

It is important that your contact information is current. If you are submitting an application and have relocated, please be sure to notify our admissions department of your current contact information.

Important Applicant Information:

- Applicants are required to have some form of identification. If you do not have proper identification at the time of application, please begin the process to receive some form before admittance.
- Applicants requiring detoxification must do so prior to entry. If you need a referral, please contact our admissions department for a referral to a detox in our area.
- Applicants are strongly encouraged to enter the program with at least a 30-day supply of all currently prescribed medications (with the exclusion of prescribed narcotics or other prohibited medications.)
- A physical examination must be done prior to admission. Tests for HIV, STD's, Tuberculosis, and Hepatitis are required as part of the physical exams.

- All Applicants are required to take a mandatory on site drug test before being admitted.

Thank you again for your interest in Warrior Discipleship Ministry. We look forward to the opportunity to serve you as you take this important step in your recovery.

Applying for:
□ Long Term Discipleship Program □ 28 Day Spiritual Boot Camp

First Name: _____ SSN: _____
Middle Name: _____ DOB: _____/_____/_____ Age: _____
Last Name: _____ Height: _____ Weight: _____

Current Address:
Street: _____
City: _____
State: _____ Zip: _____
Phone: _____
Email: _____

Legal Resident of:
State: _____
County: _____

Do you have any relatives or friends currently in our program? □ Yes □ No
If yes, who? _____

Have you previously been in our program? □ Yes □ No
If yes, when? _____

Marital Status: □ Single □ Married □ Divorced □ Engaged □ Separated

Citizenship: □ United States □ Other

Race: □ American Indian □ Asian □ Black □ Hispanic □ Multi Racial □ White □ Other

Do you read and write English at a 5th grade level or above? □ Yes □ No

Do you have a High School Diploma? □ Yes □ No
Do you have a GED? □ Yes □ No

I need help with: (Check all that apply) □ Alcohol Addiction □ Drug Addiction □ Other:
_____

Do you use tobacco? □ Yes □ No

Have you ever been treated for substance abuse? □ Yes □ No
If yes, how many times? _____

Prior Treatment Facility:
List the most recent treatment program you have been in.
Name of Facility: _____

Address: _____
City: _____ State: _____
Dates of Treatment: _____/_____/_____ to _____/_____/_____
Reason for Treatment: _____
Did you complete the program? □ Yes □ No

Physical Health:

PLEASE NOTE THAT ALL OUT OF STATE APPLICANTS MUST HAVE A PHYSICAL COMPLETED PRIOR TO ADMISSION.

Medical History: Check all that apply to your current and past conditions.

□ Asthma	□ Allergies	□ HIV/AIDS
□ Alcohol Abuse	□ Drug Abuse	□ Respiratory Problems
□ Migraines	□ Head Trauma/TBI	□ Seizures
□ Diabetes □ Type 1 □ Type 2	□ Heart Condition	□ STI/STD
□ Respiratory Problems	□ Hepatitis	□ Tuberculosis
□ Mental Illness	□ High Blood Pressure	□ Other: _____

Do you have any other medical concerns? _____
_____

Are you currently being treated by a doctor? □ Yes □ No

Name of Primary Doctor: _____
Address: _____
City: _____ State: _____
Dates of Treatment: _____/_____/_____ to _____/_____/_____
Reason for Treatment: _____

Non-Mental Health Medications:

List all current non-mental health medications:

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

Are you being treated with prescribed narcotics? □ Yes □ No
If yes, what medications? _____
Applicants on prescribed narcotics will need to complete the regimen prior to admission or switch to non-narcotic pain medications.

Are you allergic to any medications? □ Yes □ No
If yes, what medications? _____
_____

Special Needs:

Do you have any type of disability? □ Yes □ No Type: _____
Do you have any type of medical restrictions? □ Yes □ No Type: _____

Do you have any other type of special needs? □ Yes □ No Type: _____
Do you have any allergies? □ Yes □ No Type: _____
Do you require a special diet?* □ Yes □ No Type: _____
*Special dietary accommodations can be made for diabetics only. All others will be required to eat the meals as provided.

Mental Health:
Have you ever been treated for mental disorders? □ Yes □ No
If yes, when? _____/_____/_____ to _____/_____/_____
Have you ever been treated by a psychiatrist/psychologist? □ Yes □ No
If yes, when was your last visit? _____/_____/_____

Mental Health History: Check all that apply to your current and past conditions.

□ ADD/ADHD	□ Depression	□ Personality Disorder
□ Anger Problems	□ Hallucinations	□ Physical Abuse
□ Anorexia	□ Hearing Voices	□ PTSD
□ Anxiety Disorder	□ Homicidal Tendencies	□ Schizophrenia
□ Bipolar Disorder	□ Insomnia	□ Suicide Attempts
□ Brain Injury	□ Multiple Personalities	□ Suicidal Thoughts
□ Bulimia	□ Paranoia	□ Other: _____

Have you thought about or attempted suicide in the past 3 months? □ Yes □ No
If yes, how long ago? _____

Name of Primary Psychiatrist/Psychologist: _____
Address: _____
City: _____ State: _____
Dates of Treatment: _____/_____/_____ to _____/_____/_____
Reason for Treatment: _____

Mental Health Medications Currently Taking:

Medication Name:	Dosage:	Reason:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Financial Information:
Are you presently employed? □ Yes □ No
If yes, what is your monthly income? _____

Do you receive any other income (SSI, disability, etc.?) □ Yes □ No
If yes, that is the monthly amount? _____

Do you currently receive any government assistance? □ Yes □ No
If yes, what type? _____

Do you have any type of medical insurance? □ Yes □ No
If yes, please provide the following information:
Insurance Provider: _____
Member ID Number: _____
City: _____ State: _____
Zip: _____ Phone Number: _____

Do you gave a case worker: □ Yes □ No
If yes, please provide the following information:
Case Worker's Name: _____
Address: _____
City: _____ State: _____
Zip: _____ Phone Number: _____
Fax Number: _____

Emergency Contacts:
Primary Contact Name: _____
Relationship: _____
Address: _____
City: _____ State: _____
Zip: _____ Phone Number: _____
Alternate Phone: _____
Email: _____

Secondary Contact Name: _____
Relationship: _____
Address: _____
City: _____ State: _____
Zip: _____ Phone Number: _____
Alternate Phone: _____
Email: _____

Legal Issues:
Are you currently on probation? □ Yes □ No State/County: _____
Are you currently on parole? □ Yes □ No State/County: _____
Do you currently have any court cases pending? □ Yes □ No State/County: _____
Are you currently under investigation for anything? □ Yes □ No State/County: _____
Do you currently have any outstanding warrants? □ Yes □ No State/County: _____

Have you ever been convicted of a violent crime? □ Yes □ No If yes, please list each conviction and date:
_____
_____

Have you ever been convicted of a sex related crime? □ Yes □ No If yes, please list each conviction and date:
_____
_____

Are you currently facing charges for a violent or sex related crime? □ Yes □ No If yes, please describe fully:

_____
_____

Are you required to register as a sexual or predatory offender? □ Yes □ No
Probation or Parole Officer's Name: _____
Address: _____
City: _____ State: _____
Zip: _____ Phone Number: _____
Fax Number: _____

Attorney's Name: _____
Address: _____
City: _____ State: _____
Zip: _____ Phone Number: _____
Fax Number: _____

By my signature below, I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that should an investigation disclose untruthful or misleading answers, I may be discharged from Warrior Discipleship Ministry. Furthermore, I understand that Warrior Discipleship Ministry is a Christ-Centered program and that I have made a free and independent choice to enroll. I understand that other program options are available to me and I have had an opportunity to request a referral.

Please initial indication that you have read and agree to abide by the following documents:

_____ Program Policies and General Information

_____ Prohibited Medication List

_____ Compliance and Faith Based Activities

_____ Release of Confidential Information

_____ _____
Applicant's Signature Date

Voluntary Compliance with Christ Centered Activities

Warrior Discipleship Ministry is a Christ Centered program that is based upon Christian principles and practices. As such, Warrior Discipleship Ministry is only an appropriate option for people desiring such a program and who are willing to commit to fully participate in it. If you do not want to participate in this program and follow the requirements listed below, please contact our admissions department and we will provide a referral list of other programs that may better your needs.

No provider of substance abuse services receiving federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against anyone on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in religious practice. **If you object** to the spiritual education model utilized by Warrior Discipleship Ministry and object to the religious character of this organization, federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternate provider must be of a value not less than the value of the services you would have received from this organization.

Please read each item carefully and initial your acceptance to each program requirement.

Upon admittance to Warrior Discipleship Ministry, I agree to the following:

_____ I will participate in daily devotions, Bible reading, and prayer.

_____ I will participate in the weekly church services and special events.

_____ I will participate in lecture classes, individualized study courses, group studies, individual counseling, and other program components that are based on Christian principles.

_____ I will attend and serve in all scheduled outreaches.

My signature below indicates that I have carefully considered the Christian nature of the program and have made a free and independent choice to participate in the Warrior Discipleship Ministry program. I also acknowledge that I have been given the opportunity to ask for a referral list of other faith-based and secular programs.

_____ _____

Applicant's Signature Date

Prohibited Medications List

These medications, or the generic forms of these medications, are not allowed in the Warrior Discipleship Ministry Residential Programs.

Antipsychotics:
Abilify, Geodone, Mellaril, Seroquel, Clozaril, Haldol, Risperdal, Zyprexa, Thorazine, Remeron

Pain Medications:
Loratab, Hydrocodone, Oxycontin, Percocet, Codeine, Darvocet, Lyrica, Methodone, Suboxone, Subutex, Naltrexone, Diladid, Ultram, Tramadol

Mood Stabilzers:
Dapakote, Lithium, Topamax, Lamictal, Tegretol, Trileptal
(These medications are only allowed if prescribed for documented seizure disorders and must be accompanied by a letter from your treating physician).

Muscle Relaxers:
Flexeril, Soma

Antidepressants:
Remeron, Elavil, Seroquel, Sarotex, Seroten, Typtanal, Tryptizol, Amitriptyline

Antianxiety Medications:
Valium, Xanax, Klonipan, Ativan, Gabapentin

Sleep Aids:
Ambien, Halcion, Lunestra, Restoril, Sonata

ADD/ADHD Medications:
Adderall, Concerta, Focalin, Provigil, Ritalin