



1219 West Tharpe Street • Tallahassee, Florida 32303
www.thelivingharvest.org • 850-900-5930

Application for Residency

The Living Harvest (TLH) is a Faith based / 12 Step Residential Christian Recovery Program and Ministry for men. The primary goal and focus of TLH is to facilitate a stable environment that gives individuals an opportunity to rebuild their lives. TLH serves to empower men who have been criminally justice involved and/or are struggling with substance abuse or other addictions to become responsible, functioning individuals in their communities.

Program: TLH provides an opportunity for you to build a new life conforming to Christian principles. We provide a loving and caring environment with accountability, mentoring, life skills tools and resources which will help you become responsible, functioning individuals to your family and in your community.

Accountability: Residents develop a character of respect, integrity, and humility as they follow the program structure of TLH; i.e. Progressive Program, Daily Schedule, House Rules, Cause for Disciplinary, Discharge, etc. as well as staff directives. These directives will seem restrictive at first, but it is important in recognizing that your way has not worked for you in the past and you are willing to make a change. As you progress, the rules will relax and let you transition to living in the real world again, but only when you demonstrate that you are ready.

Guidelines:

- A. Honor House rules and staff directives with diligence and respect (see program rules for details).
- B. Break from dysfunctional people, places, and things that are unhealthy influences in your lives.
- C. Agree to a search of your person and possessions upon arrival or at any time thereafter, while a resident of The Living Harvest.
- D. Agree to random alcohol and drug testing upon request from TLH Staff.
- E. All postal mail is subject to search by TLH staff.
- F. The Living Harvest reserves the right to discharge any resident at any time for not complying with the Code of Conduct or Program Description. If discharged, you agree to leave without disruption to staff or other residents.

If you share the perspective offered by TLH, you are welcome to make official application admission by signing below. Your signature denotes that you have voluntarily and free of coercion, read and agree to the guidelines of TLH as referenced in this document and release TLH to acquire information from the Department of Corrections or other institutions to determine eligibility. Please also review the medical information release form attached in Appendix A at the end of this packet. Upon the review of your completed application and the available bed space you will be notified as to acceptance. To contact TLH call (850) 900-5930, email: office@thelivingharvest.org; or mail to:

TLH Admissions
1219 W. Tharpe Street
Tallahassee, FL. 32303

Applicant's Name (PRINT): _____

Applicant's Signature: _____ Date: _____

Expected Release Date (or desired admission date): _____

IDENTIFICATION INFORMATION

Date: _____

First Name: _____ Last Name: _____ M.I.: _____

DC # (If applicable) _____

Current Facility and Address _____

State: _____ Zip Code: _____

SS#: _____ Citizenship: Yes _____ No _____

Phone Number: _____ Email: _____

Age: _____ D.O.B: _____ Marital Status: _____ Race: _____

Spouse Name: _____ Address: _____

No. of Children: _____ Are you a veteran? _____

Level of Education: _____

Do you have an I.D.: Yes No State Issued: _____

Do you have a valid drivers' license: Yes No State Issued: _____

Birth Certificate: Yes No Social Security Card: Yes No

What languages do you speak? _____

Give one word description of your life now: _____

FINANCIAL ASSISTANCE

Are you currently receiving assistance through the programs listed below, if so, provide the amount per month.
(check all that apply)

SSI	\$ _____	Cash Assistance	\$ _____
SSDI (Disability)	\$ _____	Veteran Benefits	\$ _____
Food Stamps	\$ _____	WIC	\$ _____
HUD	\$ _____		

Emergency Contact 1

Name: _____

Address: _____

Phone: _____

Email: _____

Relationship: _____

Emergency Contact 2

Name: _____

Address: _____

Phone: _____

Email: _____

Relationship: _____

CRIMINAL JUSTICE SYSTEM

Do you have any Detainers? _____

Charges Pending? _____

City: _____ Judge: _____

Lawyer's Name: _____ Phone #: _____

Classification Officer's or Release Officer's Name: _____ Phone #: _____

Next Hearing Date: _____

When you are released will you be on Probation/Parole or Conditional Release?

Date of sentencing: _____

Address of Probation Office: _____

Terms of Probation/Parole: _____

Ever Violated Probation/Parole? _____ When? _____

Any other legal restrictions: _____

Prior Criminal History/Charges

Date	City	Charge	Disposition

***FAILURE TO PROPERLY DISCLOSE FULL CRIMINAL HISTORY WILL PRECLUDE YOU FROM ADMISSION WITH TLH. TLH RESERVES THE RIGHT TO REVOKE ADMISSION AT ANY TIME UPON DISCOVERY OF IMPROPERLY DISCLOSED CRIMINAL HISTORY**

EMPLOYMENT HISTORY

LIST YOUR THREE MOST RECENT JOBS:

EMPLOYER	Position	Time Frame	Reason for leaving	Attitude toward job
1.				
2.				
3.				

What kind of work are you trained to do? _____

What kind of work are you interested in? _____

YOUR HEALTH AND MEDICAL INFORMATION

With which, if any, mental health disorders have you been diagnosed in the past (depression, bipolar, schizophrenia, etc.)?

What medications are you currently prescribed? _____

What medications are you currently taking? _____

Previous Medication History: _____

Please list any current allergies or physical complaints and health problems:

SUBSTANCE ABUSE HISTORY

Check all that you have abused and when:

DRUG	USED/PAST	USED/PRESENT	HOW OFTEN/FREQUENCY	HOW LONG/DURATION
Alcohol				
Marijuana				
Hallucinogen				
Barbiturates				
Amphetamine				
Methamphetamine				
Heroin				
Methadone				
Cocaine Opiates				
Other?				
Other?				

QUESTIONS : (Circle Yes or No)

- | | | |
|--|-------|----|
| 1. Have alcohol/drugs ever been a problem for you? | Yes | No |
| 2. Have you ever been arrested under the influence? | Yes | No |
| 3. Have you ever needed more alcohol/drugs to get the same affect? | Yes | No |
| 4. Has anyone ever complained about your behavior? | Yes | No |
| 5. How old were you when you noticed your problem? | _____ | |
| 6. Have you ever tried to cut down or stop using alcohol / drugs? | Yes | No |
| If so, When? _____ | | |
| 7. Have you ever attended any 12 Step Recovery meetings before? | Yes | No |
| 8. Are you willing to work with a sponsor? | Yes | No |

Please take time to answer the following questions and answer them in as much detail as possible.

Please tell us why you want to come to The Living Harvest

What are your long term goals?

Please tell us about your faith and your relationship with God?

How have you tried to live your faith? Can you think of any ways in which you have not lived your faith?

Do you like to take initiative in life or be directed as to what to do?

What do you do with your free time?

How do you deal with authority figures?

How do you feel about having to go frequently to recovery group meetings?

Do you believe in 12 step recovery programs?

Please tell us about your relationships with your family:

Have you come to the point in life where you feel that are ready to follow the direction of this program even if it takes you well outside your comfort zone? In other words, are you tired enough of doing it your own way and are you ready to surrender?

Please list all programs (Faith Based and Other) you have participated in during incarceration or otherwise:

How do you feel about the restrictions that will be placed on you by this program (read the Resident Handbook before answering this question)?

Applicant Signature _____

Date _____

Thank you for your interest in our program. Your application will be processed as quickly as possible from the time we receive it. Please note that we will not process incomplete applications. If you do not hear from our Admissions Department regarding your application, please feel free to contact us. Please return your application to:

The Living Harvest, Inc.
Admissions Department
1219 W. Tharpe Street
Tallahassee Florida 32303

ALL SECTIONS AND QUESTIONS MUST BE COMPLETED IN ORDER TO PROCESS APPLICATION

Appendix A: HIPAA Privacy Authorization Form

The following contains an authorization for use or disclosure of Protected health Information as required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164:

1. Authorization

I authorize _____ (Healthcare Provider) to use and disclose the protected health information described below to _____ (Individual Seeking Information).

2. Extent of Authorization

I authorize the release of my complete health record (including records related to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol drug abuse):

_____ (Check to Confirm Consent)

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. I understand that I have the right to revoke this authorization in writing at any time. I also understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Federal or state law.

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative and His or Her Relationship Patient

Date
