



HOME OF GRACE Admissions Application

Phone: (228) 826-5283 / Fax: (228) 826-1663
PO Box 5009, Vancleave, MS 39565
admissions@homeofgrace.org

A. BASIC INFORMATION

Today's Date:

I am applying

- For myself For someone else

Previously enrolled?

- Yes No

What year?

Did you graduate?

- Yes No

APPLICANT INFORMATION

Sex Male Female

Last 4 of SSN

First Name

M.I.

Last Name

Suffix (Jr, Sr, III)

Maiden Name

Date of Birth

Address 1

Address 2

City

State

Zip

Email

Cell Phone

Home Phone

How did you hear about the Home of Grace?

Marital Status:

- Single
 Married
 Separated
 Divorced
 Widowed

Race/Ethnicity:

- American Indian or Alaskan Native
 Asian or Pacific Islander
 Black or African American
 Hispanic
 White or Caucasian
 Multiple Ethnicity / Other

Religious Denomination:

Highest level of education:

- Primary school
 Some high school, but no diploma
 High school diploma (or GED)
 Some college, but no degree
 2-year college degree
 4-year college degree
 Graduate-level degree
 None of the above

Those without a high school diploma or GED must participate in the Adult Education Program. The GED test fee is \$93 plus practice testing fees.

Occupation, skills, trade:

Are you a U.S. Veteran? Yes No

B. ADDICTION HISTORY

Check all addictions abused in the past 5 years:

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Gambling | <input type="checkbox"/> Over-the-Counter |
| <input type="checkbox"/> Amphetamine / Stimulants <i>e.g. Adderall, Ritalin</i> | <input type="checkbox"/> GHB / GBL | <input type="checkbox"/> Pornography / Sex |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Hallucinogens <i>e.g. Acid / LSD, PCP, Shrooms</i> | <input type="checkbox"/> Prescription Opioids <i>e.g. Lorcet, Lorlab, Methadone, Morphine, Oxycotin, Suboxone</i> |
| <input type="checkbox"/> Bath Salts | <input type="checkbox"/> Heroin | <input type="checkbox"/> Spice |
| <input type="checkbox"/> Benzodiazepines / Sedatives <i>e.g. Librium, Klonopin, Valium, Xanax</i> | <input type="checkbox"/> Inhalants / Huffing | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Kratom | <input type="checkbox"/> Tobacco / Nicotine |
| <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Marijuana / THC | <input type="checkbox"/> Other Addiction: |
| <input type="checkbox"/> Fentanyl | <input type="checkbox"/> Methamphetamine | <input type="text"/> |

Do you use tobacco products?

- Yes No

How many packs per day?

Which is your PRIMARY addiction?

Which is your SECONDARY addiction?

- We STRONGLY urge residents to stop using tobacco.
- Limited smoking and smokeless tobacco (in pouches only) are allowed in designated areas only
- eCigarettes and vapors are NOT allowed.
- Pregnant residents and residents using inhalers are NOT allowed to smoke.



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C. MEDICAL INFORMATION

Health history (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Allergies ¹ | <input type="checkbox"/> Hepatitis ³ |
| <input type="checkbox"/> Anxiety attacks | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures ⁴ |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Severe depression |
| <input type="checkbox"/> Dental or bad teeth | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Suicide attempts ⁵ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Handicaps ² | <input type="checkbox"/> None |
| <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Heart problems | <input type="text"/> |

Have you ever been in treatment for substance abuse? How many times?

Yes No

Who is responsible to pay your medical expenses?

¹ List all allergies:

² Describe any handicaps or physical limitations:

³ Hepatitis Type:

⁴ Most recent seizure:

⁵ No. of suicide attempts:

⁵ Most recent suicide attempt:

Height

Weight

Recent or upcoming hospitalizations or surgeries:

Have you ever been diagnosed with a psychiatric or mental disorder? Yes No

If so, please describe:

Will you need medication refills? Yes No

List all currently prescribed medication (name, purpose, how long have you been taking?):

MATERNITY INFORMATION

Are you pregnant? Yes No

Deliver due date: No. weeks pregnant: No. of previous deliveries:

Any premature deliveries? Yes No

If so, please explain:

• **Pregnancy test results are required by ALL WOMEN**

- You will need to submit medical records, pregnancy assessment or doctor's visit documentation as well as a statement from a medical professional confirming the due date and a healthy pregnancy.
- Pregnant residents must not be more than 15 weeks pregnant at intake. Pregnant residents are NOT allowed the use of tobacco products.
- OUT-OF-STATE MEDICAID is NOT accepted at Mississippi Pharmacies or Medical Facilities. Therefore, prior arrangements must be made before entering the program for physician payment and pre-approved prescribed medications. Ex. Prenatal vitamins, etc.
- OBGYN Physicians DO NOT accept Out-of-State Medicaid. For maternity fees, please contact one of our local OBGYN clinics. Gulf Coast OBGYN (Pascagoula, MS): (228) 762-8136 or Mississippi Coast OBGYN (Ocean Springs, MS): (228) 872-1505.
- Home of Grace staff will arrange escorted transportation to and from physician appointments when all financial arrangements have been completed.

- Misrepresentation of your medical condition will result in immediate dismissal with no refund. Ensure that all medical information submitted is complete and accurate.
- All travel arrangements, medical appointments, dental appointments, chiropractic care, vision appointments, and surgeries should be scheduled AFTER the program completion date.
- Resident must be physically detoxed and able to participate in required daily activities prior to enrollment. The Home of Grace is NOT a medical facility and CAN NOT provide medically supervised detox. Contact your local hospital for a list of detox facilities.

- PROHIBITED MEDICATIONS include (but are not limited to) barbiturates, narcotics, opiate blockers, sleep-aids, and mood altering drugs.
- ALL MEDICATIONS (prescribed and over-the-counter) must be PRE-APPROVED prior to intake and turned in upon arrival.
- Prior arrangements should be made BEFORE entering the program for a PRE-APPROVED 3-month supply of prescribed medication refills (ex. blood pressure medication, etc). Request local pharmacy list from Admissions for prescription transfers.



D. EMERGENCY CONTACTS

CONTACT #1

Name Relationship to applicant

Contact Information (phone, address, email, etc):

CONTACT #2

Name Relationship to applicant

Contact Information (phone, address, email, etc):

E. LEGAL EVALUATION

Do you have any pending legal obligations? Yes No
e.g. DHS, Family Court, Civil, etc.

Will you be under court order while enrolled? Yes No

Do you have court dates pending? Yes No

Are you under probation / parole? Yes No

Are you applying from jail?
If so, where?

Have you ever pled guilty or been convicted of a crime?

Yes No

List any felonies, misdemeanors or pending charges:

Attorney Contact Information
(name, email, phone, fax):

Probation / Parole Officer Contact Information
(name, state and county, phone, email):

List all pending court dates (with court name, city and state):

F. AGREEMENTS

ENROLLING CLIENT MUST INITIAL EACH BOX:

Detoxification: I understand that I must be safely detoxed before intake, otherwise, I will not be admitted.

Medical Policy: I understand that misrepresentation of my medical condition will result in dismissal with no refund. I affirm that all information submitted is complete and accurate.

Intake Reschedule Policy: I understand that I am responsible to arrive no later than my appointed intake time, and a postponement for any reason will require a non-refundable deposit of \$500 before another intake can be rescheduled.

Postpone Obligations: I understand that I am responsible to postpone ALL appointments (legal, medical, personal, etc) until the completion of the three-month program.

No Refund Policy: I understand that NO REFUND of any amount will be offered under any circumstance.

Statement of Faith: I have read and understand the Home of Grace's [Statement of Faith](#).

Signature of applicant:

Signature of cardholder / primary payer:

Date: