APPLICATION FOR ADMISSION

4000 SOUTH WEST AVENUE
PO BOX 88145
SIOUX FALLS, SD 57109-8145
(605) 332-3273 FAX (605) 332-6410

Name: _____ Social Security #: _____ Date Submitted: _____

Home Address: _____ County: _____
(street, city, state, zip code)

Date of Birth: _____ Place of Birth: _____ Phone#: _____

*Race or Ethnic Origin: _____*Gender: _____Male _____Female

In Case of Emergency Notify:

Name: _____ Phone #: _____

Address: _____

_

Relationship to above person: _____

Referred by: _____

Reason for Admission (circle one): Self Admit, Parole, Court Services, IMT, Drug Court, MSA, Keystone, Attorney, Federal Supervised Release/Pre-Trial, BOP Custody

STATE/FEDERAL/OTHER IDENTIFICATION #: _____

REFERRAL AGENT: _____

Are you willing to abstain from the use of alcohol and all other drugs (including marijuana) while a resident of the Glory House? _____YES _____NO

*Glory House does not discriminate based on race, color, gender, age, religion, national origin, marital status, political belief, mental or physical handicap. Government funding agencies require this information for statistical purposes only.

The mission of the Glory House is helping people claim their lives with Christian compassion, resources and support.

CHEMICAL USE HISTORY

Have you ever had a previous treatment for chemical dependency? Yes___ No____

When: Month & Year	Where: Name of Facility and Address	Completed? Yes/No	Inpatient Treatment	Outpatient Treatment	Length of Sobriety after Treatment

Have you ever attended a 12 step meeting or worked with a sponsor?_____

Have you ever stayed in a halfway house before?_____ Where/when?_____

What is your longest period of sobriety from alcohol? _____ Drugs? _____

Do you feel you have or have had a problem with alcohol? Yes No Drugs? Yes No
If yes, how long has your alcohol/drug use been causing you problems?_____
_____

ALCOHOL USE:

Age of first use	**Frequency of use**	**Progression of use/ ages and amounts**	**Usual amount used**	**Maximum amount used**	**Date of last use**

Have you ever experienced any of the following due to your alcohol use?	**Yes**	**No**
Tremors of hands, tongue or eyelids?		
Nausea and/or vomiting		
Fatigue/weakness		
Autonomic hyperactivity (sweating, elevated blood pressure)		
Anxiety/Nervousness		
Depressed moods		
Irritability		
Hallucinations and/or illusions		
Headaches		
Insomnia		
Blackouts		
Used alcohol to relieve or avoid withdrawal symptoms		
Shakes (after heavy drinking)		
Needed more to achieve desired effect (tolerance)		
Markedly diminished effect with continued use of the same amount		
Overdose		
Tried to slow down or stop drinking		

Drank more than you intended to		
Stayed drunk for more than one day		
Seizures		
Cravings (wanting alcohol)		
Alcohol poisoning (passing out, unresponsive)		
Gone without food to drink		
Work/school problems due to your alcohol use		
Used before or during work/school		
Quit a hobby or recreational activity to drink or because of it		
Used alcohol in dangerous situations (swimming, driving, operating machinery)		
Legal problems		
Physical fights while under the influence of alcohol		
Involved in alcohol-related auto accidents		
Injured in any way (explain)		
Problems with family/children/friends		
Alcohol-related health problems (liver, kidneys, throat, mouth)		
Have you ever had to go to an emergency room or physician's office for an alcohol related illness? or accident?		
Have you ever been hospitalized for alcohol intoxication or withdrawal?		

CANNABIS/HASHISH USE:

Have you ever used marijuana, THC, pot, hashish, K2, etc.: Yes____ No_____

(Following are not applicable if the above was answered "no.")

Name of Drug	Age of first use	Method of use	Frequency of use	Duration of use	Usual amount used	Maximum amount used	Date of last use

Have you experienced the following from your Cannabis/Hashish use?	Yes	No
Chronic cough		
Headache		
Muscle cramps		
Decreased exercise tolerance		
Bronchitis		
Irritability		
Sleep disturbances		
Increased heart rate		
Depressed moods		
Cravings		
Needed more to get high (tolerance)		
Quit a hobby or recreational activity because of use		
Used in dangerous situation (swimming, driving, operating machinery)		

Work/school problems due to use		
Used before or during work/school		
Tried to slow down or stop use		
Lack of motivation		
Involved in fights (explain)		
Injured in any way (explain)		
Problems with family/children/friends		
Health problems from using (liver, kidneys, stomach, throat, mouth)		
Legal problems		

COCAINE USE:

Have you ever used crack, coke, powder, white, snow, flake, etc.? Yes_____ No_____

(Following are not applicable if the above was answered "no.")

Name of Drug	Age of first use	Method of use	Frequency of use	Duration of use	Usual amount used	Maximum amount used	Date of last use

Have you experienced the following due to your Cocaine use?	Yes	No
Fatigue		
Nausea/Vomiting		
Depression		
Sweating/Chills		
Irritability		
Preoccupation with obtaining cocaine		
Agitation		
Cravings		
Insomnia/hypersomnia		
Anxiety		
Increased appetite		
Vivid/unpleasant dreams		
Hallucinations/delusions		
Tolerance		
Tried to slow down or stop use		
Stayed high for more than one day		
Used for a longer period than intended		
Used more to relieve/avoid withdrawal symptoms		
Problems with family/children/friends		
Health problems related to your use (liver, kidneys, stomach, throat, mouth)		
Legal problems		

HALLUCINOGEN USE:

Have you ever used LSD, acid, DMT, peyote, buttons, mushrooms, mescaline, psilocybin, etc.? Yes___ No____

(Following are not applicable if the above was answered "no.")

Name of Drug	Age of first use	Method of use	Frequency of use	Duration of use	Usual amount used	Maximum amount used	Date of last use

Have you experienced the following due to your Hallucinogen use?	Yes	No
Marked anxiety or depression		
Fear of losing your mind		
Paranoid ideations		
Impaired judgment		
Impaired social or occupational functioning		
Illusions and/or hallucinations		
Dilated pupils		
Sweating		
Heart palpitations		
Blurring of vision		
Tremors		
Perceptual changes occurring in a state of being fully awake or alert		
Depersonalizations (feeling as if you aren't in your body)		
Derealizations (altered perception of reality)		
Incoordination		
Tolerance		
Used for a longer period than intended		
Tried to slow down or stop use		
Have you ever had a flashback		
Problems with your family/friends due to your use		
Health problems related to your use (liver, kidneys, stomach throat, mouth)		
Legal problems		

HEROIN/OPIATE & OTHER ANALAGESIC USE:

Have you ever used opium, heroin, Morphine, Hydrocodone, Oxycodone, Fentanyl, etc.? Yes____ No____

(Following are not applicable if the above was answered "no.")

Name of Drug	Age of first use	Method of use	Frequency of use	Duration of use	Usual amount used	Maximum amount used	Date of last use

Have you experienced the following due to your Heroin/Opiate use?	Yes	No
Cravings for an opiate		
Muscle aches/cramps		
Fever		
Tremors		
Increased heart rate		
Diarrhea		
Yawning		
Nausea/vomiting/loss of appetite		
Dilated pupils		
Goosebumps/sweats		
Rhinorrhea (runny nose)		
Lacrimation (watery eyes)		
Tolerance		
Stayed high for more than one day		
Used for a longer period than intended		
Used more to relieve or avoid withdrawal symptoms		
Tried to slow down or stop use		
Problems with family/children/friends		
Health problems related to your use (liver, kidneys, stomach throat, mouth)		
Legal problems		

INHALANT USE:

Have you ever sniffed/inhaled aerosols, lighter fluid, gasoline, model cements, solvents, rush, white out, glue, paint, etc.?
Yes_____ No____

(Following are not applicable if the above was answered "no.")

Name of Drug	Age of first use	Method of use	Frequency of use	Duration of use	Usual amount used	Maximum amount used	Date of last use

Have you experienced the following due to your Inhalant use?	Yes	No
Sleep disturbances		
Shakes/tremors		
Nausea/sweats		
Irritability		
Abdominal discomfort		
Chest discomfort		
Loss of motivation		
Stayed high for more than one day		
Used more or for a longer period than intended		
Used more to relieve or avoid withdrawal symptoms		
Tried to slow down or stop use		
Problems with family/children/friends		
Health problems related to your use (liver, kidneys, stomach throat, mouth, lungs)		

NICOTINE USE:

Do you:	Yes	No
Smoke cigarettes/cigars/pipe Age of first use:		
If answered yes – how many packs per day:		
Used smokeless tobacco, if yes how much per day:		
Have sores in your mouth		
Ever cough up blood		
Attempted to quit or control your use of nicotine		
If no, have you used tobacco? How long ago:		

AMPHETAMINE USE:

Have you ever used methamphetamines, ecstasy, etc? Yes____ No_____

(Following are not applicable if the above was answered "no.")

Name of Drug	Age of first use	Method of use	Frequency of use	Duration of use	Usual amount used	Maximum amount used	Date of last use

Have you experienced the following due to your Amphetamine use?	Yes	No
Depression		
Agitation		
Insomnia/hypersomnia		
Vivid/unpleasant dreams		
Anxiety		

Irritability		
Fatigue		
Increased appetite or decreased		
Stayed high for more than one day		
Used more or for a longer period than intended		
Used more to relieve or avoid withdrawal symptoms		
Tolerance		
Tried to slow down or stop use		
Used before or during work/school		
Work/school problems due to use		
Problems with family/children/friends		
Health problems from using (liver, kidneys, stomach, throat, mouth)		
Legal problems		

STIMULANT USE:

Have you ever used speed(ers), white crosses, ephedrine, uppers, etc.? Yes___ No__

(Following are not applicable if the above was answered "no.")

Name of Drug	Age of first use	Method of use	Frequency of use	Duration of use	Usual amount used	Maximum amount used	Date of last use

Have you experienced the following due to your stimulant use?	Yes	No
Depression		
Agitation		
Insomnia/hypersomnia		
Vivid/unpleasant dreams		
Anxiety		
Irritability		
Fatigue		
Increased appetite or decreased		
Stayed high for more than one day		
Used more or for a longer period than intended		
Used more to relieve or avoid withdrawal symptoms		
Tolerance		
Tried to slow down or stop use		
Used before or during work/school		
Work/school problems due to use		
Problems with family/children/friends		
Health problems from using (liver, kidneys, stomach, throat, mouth)		
Legal problems		

SEDATIVE, HYPNOTIC OR ANXIOLYTIC USE:

Have you ever used a barbiturate, tranquilizer, sleeping medication, valium, ativan, zanax, Librium, etc? Yes___ No____

(Following are not applicable if the above was answered "no.")

Name of Drug	Age of first use	Method of use	Frequency of use	Duration of use	Usual amount used	Maximum amount used	Date of last use

Have you experienced the following due to your Sedative, Hypnotic or Anxiolytic use?	Yes	No
Anxiety		
Tremors		
Shakiness		
Tingling		
Diarrhea		
Nausea and/or vomiting		
Dizziness		
Agitation		
Insomnia		
Headaches		
Blurred vision		
Seizures		
Muscle aching/twitching		
Concentration difficulties		
Stayed high for more than one day		
Used more or for a longer period than intended		
Used more to relieve or avoid withdrawal symptoms		
Tried to slow down or stop use		
Tolerance		
Work/school problems		
Problems with your family due to your use		
Problems with your children due to your use		
Problems with your extended family due to your use		
Problems with your friends due to your use		
Health problems from using (liver, kidneys, stomach, throat, mouth)		
Legal problems		

PHENCYCLIDINE USE:

Have you ever used PCP, angel dust, etc.? Yes____ No____

(Following are not applicable if the above was answered "no.")

Name of Drug	Age of first use	Method of use	Frequency of use	Duration of use	Usual amount used	Maximum amount used	Date of last use

OTHER SUBSTANCES, OVER THE COUNTER USE:

Do you use antihistamines, Nytol, Nyquil, No-Doz, laxatives, Primatene, diet pills, Mydol, etc.? Yes____ No____

Name of Drug	Age of first use	Method of use	Frequency of use	Duration of use	Usual amount used	Maximum amount used	Date of last use

GAMBLING HISTORY:

What forms of gambling do you participate in?

	Yes	No		Yes	No
Video Lottery			Slot Machines		
Black Jack			Powerball		
Bingo			Sports		
Scratch Tickets			Pull Tabs		
Poker (cards)			Dog Racing		
Horse Racing			Other(s)		

GAMBLING HISTORY CONTINUED:

How much do you spend a month on gambling?_____

How often do you gamble?_____

Do you feel you have a gambling problem? Yes_____ No_____

If yes, how long has it been a problem?_____

What is the most you have won? _____ Most Lost? _____

When was the last time you gambled? _____

When gambling, have you ever:	Yes	No
Gambled the next day to win back your losses		
After winning, gambled away your winnings or part of it		
Tried to quit or control your gambling		
Gambled as a way to escape your problems		
Lost relationships, career or educational opportunities		
Gambled with increasing amounts of money		
Relied on others to help your financial situation due to gambling		
Committed illegal acts or had legal problems because of your gambling		
Felt preoccupied with gambling		
Lied to family, friends or therapist about gambling		
Felt your gambling affected your relationships with your significant other		
Felt restless or irritable when trying to control gambling		

PHYSICAL AND MEDICAL:

List any health problems: _____
_____

What is your present state of health? _____ excellent _____good _____ fair_____ poor.

Height: _____ Weight: _____ Color eyes: _____ Color hair: _____

Identifying Marks(scars/tattoos, etc.):_____

Are you currently under the care of a physician, if so for what? _____
_____

When was the last time you saw a physician and reason for visit? _____
_____ _____

Serious injuries/illnesses in past/present: _____
_____

Surgery/s (List): _____

Allergies/physical handicaps/disabilities: _____

Do you have a family history of medical problems?_____

List all medications you are on:_____

Are you free of communicable disease? _____ If no list disease(s):_____
If not sure, have you or do you wish to be tested? _____

Do you have health insurance? _____ If yes, list company_____

What health problems have you experienced due to alcohol or drug use?_____

What are you doing to stay healthy? _____

PSYCHOLOGICAL HISTORY:

Have you ever had any counseling and/or treatment for problems other than substance abuse? _____

Have you ever been diagnosed with a mental health disorder? _____

What methods of treatment were recommended? _____

Have you ever has psychiatric hospitalizations? _____

If yes, list below:

Facility/Person	Reason for counseling or hospitalization	Date

Check all that apply	Yes	No
Do you ever feel sad, down and/or depressed		
Have you ever had feelings of worthlessness, loss of pleasure, guilt, loss of energy or		

changes in sleep patterns		
Do you ever feel fearful, anxious and/or nervous		
Have you ever had a panic attack or felt shaky, numbness, tingling, unsteady or racing heart beat		
Do you have feelings of uncontrollable anger, rage or violence		
Do you find yourself being physically abusive to others		
Have you ever been physically abused		
Do you find yourself being sexually abusive to others		
Have you ever been sexually abused		
Have you been emotionally abused		
Have you experienced any trauma Explain:		
Do you have thoughts of harming other people		
Have you ever had thoughts of harming yourself		
Have you made plans to carry out any of these thoughts		
Have you ever attempted suicide If so how many times/when:		
Have you eaten without stopping or without remembering what you were doing		
Have you binged on food and then vomited		
Have you lost/gained more than 10 pounds in the last year		
Have you have sex with many people you didn't know very well		
Have you been in a relationship that didn't feel good but you couldn't be without		
Have you exercised heavily to get a rush		
Have you exercised too hard or too long at the exclusion of other important needs		

Additional explanation of any yes answers: _____
_____
_____

When was a time that your mental health symptoms were manageable? _____
_____

EDUCATION:

Do you have high school diploma or GED (circle the one that applies)

If not: What was last grade attended? _____ Why did you not complete? _____

What grades did you receive? _____Were you ever suspended/expelled? _____

How did you get along with your classmates? _____Teachers?_____

What was your favorite subject or one you did well in? _____

What problems did you experience when attending school? _____

How did alcohol and/or drugs interfere with your education? _____

List any college you have attended. _____

Do you have plans to further your education?_____

VOCATIONAL:

Are you employed _____Where?_____

If you are employed, how do you get along with coworkers/supervisors? _____

Do you need assistance with finding employment?_____

Work History: list past four jobs, starting with most recent:

Employer	Address	Dates employed	Reason for leaving

In the last three years, how many times have you changed jobs?_____

How many months have you worked during the past year?_____ Have you ever been fired? _____

List job skills and trade: _____
_____

List vocational training, certificates received and where:_____
_____

What is your ideal employment? _____

Name a time you felt successful in employment? _____

What problems have you experienced at work due to alcohol or drug use? _____

Did you serve in the military? _____YES _____ NO
List branch, where and dates served:_____

Are you a War veteran? _____YES _____NO If yes, list which war: _____

Type/date of discharge: _____

FINANCIAL:

Current source of income: _____ Any income from family/amount: _____

Annual gross income (before taxes) past 12 months _____

If admitted to the Glory House, how will you pay for services? _____

Are you in debt? _____ Amount: _____ Do you have difficulty managing your money? _____

What outstanding debt do you have? _____

Court ordered to pay child support? ____ Amount/payable to whom: _____

Are you behind on child or spousal support? _____ Amount: _____

Do you have fines, restitution, court costs to pay? _____ Amount/payable to whom: _____

Do you have any unusual financial concerns? _____ Explain: _____

Have you ever filed bankruptcy? _____Worked with a payee? _____

How much did you spend on substance use?_____ How did you fund your use? _____

Do you or does anyone in your home receive government assistance? _____

Has there been a time when you felt financially secure? _____

Have you ever:	Yes	No
Sold alcohol and/or drugs		
Traded things for alcohol and/or drugs		
Pawned things for alcohol and/or drugs		
Borrowed money to buy alcohol and/or drugs		
Went without other things to buy alcohol and/or drugs		
Have you ever stolen alcohol and/or drugs		
Have you ever shoplifted for money to buy alcohol and/or drugs		
Have you ever committed a burglary for alcohol and/or drugs		

LEGAL HISTORY:

Age of first arrest? _____ Charge/s: _____
_____

Have you ever been in a juvenile institution? _____ If yes, list why/where/when:_____
_____

Have you committed any crimes while under the influence of alcohol and/or drugs?_____

Are you in prison or jail now? ____ If yes, list why/where _____

If in prison or jail, when do you expect to be released? _____

How many times have you been on state parole/probation? _____ Federal parole/probation? _____

Did you successfully complete probation/parole in the past? _____

Have you had probation/parole revoked before? _____ If yes, why _____

How many times have you been to prison? _____ How long?_____ _____

When you were in prison, did you receive any disciplinary actions including verbal reprimands? _____

List all charge/s include dates:_____
_____
_____

How do you feel about your current offense or being on probation? _____
_____

SOCIAL:

Do you have:	Yes	No
Friends that use alcohol and/or drugs Percentage_____		
Friends that try to talk you into drinking and/or using		
Friends that try to talk you out of drinking and/or using		
Friends that you can trust How many _____		
Any close friends How many _____		
A hard time trusting others		
Friends that don't have a criminal record How many _____		
Less time spent on hobbies, recreation, or leisure activities		
Lost friends due to your alcohol and/or drug use		
Friends that express concerns about your alcohol and/or drug use		
Friends you discuss your concerns about your alcohol and/or drug use		
Any gang affiliation or involvement		
Do you participate in any organized activities?		

What percentage of your time was centered on drug or alcohol related activities? _____

Do you have any talents or skills? Yes_____ No_____
If yes, what are they?_____
_____

What do you like to do for fun or relaxation (hobbies, sports, art, etc.)?_____
_____

FAMILY:

Father's Name_____Address_____

Mother's Name_____Address_____

Foster/Step Mother_____Address_____

Foster/Step Father_____Address_____

Number of brothers/ages:_____

Number of sisters/ages: _____

Step/half brothers or sisters/ages: _____

Father's Occupation: _____

Mother's Occupation _____

Were they regularly employed? _____

Were your parents divorced or separated? _____
How old were you when they separated/divorced? _____

How did you get along with your parents/siblings? _____
_____

How were you disciplined as a child? _____

Which family members are supportive of you and your lifestyle changes?_____
_____

Either of your parents deceased, which one, how old were you when they passed away? _____
_____

Have you kept close ties with your family during the past five years? _____ If no, why not? _____
_____

Does anyone in your family have a criminal record? _____Who?_____
_____

Alcohol abuse in family? ☐ Yes ☐ No Who? ☐ Mother ☐ Father ☐ other: _____

Drug abuse in family? ☐ Yes ☐ No Who? ☐ Mother ☐ Father ☐ other: _____

Looking back at your childhood, what caused you the most unhappiness? _____
_____

Did you have any significant problems as a child? ____ If yes, what? _____
_____

Did you ever run away from home? ____ Why/How many times? _____
_____

Living arrangement prior to admission to Glory House. _____

Have you moved more than twice in the last year? _____

Single: ☐ Married: ☐ Divorced: ☐ Separated: ☐Widowed: ☐ Living with significant other: ☐

If married, living with, or divorced/separated answer the following:

Current/most recent partner's name and relationship: _____

Address: _____

Partner's occupation: _____How is he/she being supported now? _____

Do you have concerns about your current relationship? _____

Give brief information about previous marriages/relationships (when married/divorced, etc.):

Name	Dates married/divorced	Reason for divorce/separation

INFORMATION ABOUT CHILDREN:

Which relationship	Name	Age/Sex	Now living with	Yours/step

Do you have any concerns with your children? _____

SPIRITUAL:

What is your spiritual preference (Baptist, Native American, Methodist, Presbyterian, Catholic, Lutheran, etc.)?
_____

When was the last time you attended a spiritual event/church? _____

Did you attend as a child? _____ Was attendance required? _____

On an average, how many times per month have you attended during the last six months?_____

List some of your basic religious/spiritual beliefs: _____
_____

	Yes	No
Do you believe in a Higher Power (example God or Tunkashila)		
Do you have any concerns about your spiritual beliefs/practices		
Do you have any religious beliefs		
Lost faith in a Higher Power		
Have you lost your dreams/goals		
Are you hopeful for the future		
Have you done things intoxicated that you would not do sober		
Do you consider yourself to be a spiritual/religious person		
Has there been a change in your religious beliefs		

What lifts your spirit?_____
_____
_____

What are your strengths?_____
_____
_____

What are your weaknesses?_____
_____
_____

What is one thing that you would like to change about yourself?_____
_____
_____

What do you do to cope with anger or other strong emotions? _____
_____
_____

What is a goal that you would like to accomplish while at Glory House? _____
_____
_____

GLORY HOUSE GUIDELINES

The following guidelines must be followed while you are a resident of Glory House. Individuals who disregard these guidelines are sanctioned according to the Sanction Levels as stated the Sanction Level document which also lists consequences if guidelines are not followed. Further clarifications of Glory House guidelines are in the Resident Handbook that you will receive upon admission.

1. During the first 14 days, residents will be restricted to the Glory House property except for work and program requirements. After the restriction period (which can be extended if sanctions are received), residents are required to be at Glory House and programming at all scheduled times.
2. While at Glory House, residents are expected to be employed full time in order to meet financial obligations, but not to the exclusion of programming.
3. Use of alcohol or drugs or presence in alcohol related establishments is not permitted.
4. Residents are expected to respect other people and property at Glory House and in the community.
5. Food and beverages are only allowed in designated eating areas, (mainly the dining room and outside the facility).
6. Residents are required to punch out, using the time clock, any time when leaving Glory House property, and to punch in upon return. A staff member must initial the time card in resident's presence.
7. Any form of physical contact or other forms of conning, manipulation or intimidation may be grounds for immediate removal from the program.
8. Residents are responsible to follow the Glory House Resident Handbook and agree to do so.

AGREEMENT TO COOPERATE WITH GLORY HOUSE PROGRAM

As a resident of the Glory House, I will comply with the Glory House guidelines, which are in effect or which may be brought into effect at a later date. I agree to participate in treatment programs, which are prescribed for me. If unemployed, I will diligently seek employment. I understand paying room and board (or rent) is my first financial obligation. I will voluntarily sign an assignment of my wages to Glory House. I understand that failure to comply with any of the Glory House Guidelines will subject me to restriction, and possible expulsion from Glory House. I understand that the Glory House does not provide medical services and any and all medical expenses incurred by me will be paid by me. I will not hold Glory House or its' employees or its' Board of Directors liable for any injury or damage, or loss by reason of any act arising out of my stay at Glory House.

In the event I violate the law, bond requirements, conditions of my placement as stipulated by referring officials, i.e., state or federal prison requirements, state or federal probation or parole requirements, and/or Glory House Guidelines, I hereby agree that Glory House officials may release information concerning me to these various authorities as it may pertain or are directly connected with my placement at Glory House.
Glory House has the right to collect money owed to the facility and may need to release the client's name and last address in collection of any debt.

I _____, certify that I have read or had explained to me the Glory House Guidelines, and I understand and will abide by them, and that I will participate in a full program of group and individual counseling and treatment, including programs listed on my treatment plan.

_____ _____
APPLICANT SIGNATURE Date

_____ _____
WITNESS SIGNATURE: Date

_____ _____
Signature of Glory House staff reviewing application Date

Revised: 6/95
Revised: 10/02
Revised: 3/04
Revised: 12/12
APPLIC.DOC