



TRANSFORMATION LIFE CENTER  
PO BOX 249  
WEST PARK, NY 12493

# INTAKE APPLICATION

P: 845-384-6511

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[WWW.TLC911.ORG](http://WWW.TLC911.ORG)

ROMANS 12:1-2

APPLICANT NAME (print)

DATE

OFFICE USE ONLY

INTAKE DATE:

GRADUATION DATE:

APPLICANT NAME (print)

DATE

**INSTRUCTIONS:** Fill in all items on this application. For questions with multiple choice answers, circle the answer(s) which apply. For questions which do not apply to you write N/A. Mail the completed application directly to Transformation Life Center.

### SECTION I - PERSONAL DATA

STATE YOUR REASON FOR APPLYING TO TLC

STREET ADDRESS

CITY STATE ZIP

HOME PHONE	WORK PHONE	CELL PHONE	AGE	U.S. CITIZEN? Y / N	DRUG OF CHOICE
DOB	HEIGHT	WEIGHT	SOCIAL SECURITY #	SPEAK ENGLISH? Y / N	LAST USED
PREVIOUS REHAB EXPERIENCE? Y / N	# OF PREVIOUS PROGRAMS	NAME OF LAST PROGRAM			DATE OF LAST PROGRAM

### SECTION II - MARITAL DATA

MARITAL STATUS	SINGLE	MARRIED	DIVORCED	SEPARATED	WIDOWED
SPOUSE NAME	# OF CHILDREN	SPOUSE AGE	SPOUSE CELL PHONE	SPOUSE WORK PHONE	
SPOUSE STREET ADDRESS					
CITY STATE ZIP					

### SECTION III - RELIGIOUS INFORMATION

RELIGIOUS AFFILIATION	ATTENDED CHURCH IN PAST YEAR? Y / N	PASTOR NAME	ARE YOU BORN AGAIN? Y / N
CHURCH NAME	CHURCH PHONE	PASTOR PHONE	

### SECTION IV - LEGAL & MISCELLANEOUS

PRIOR MILITARY SERVICE? Y / N	SERVICE DATE	PROBLEM WITH ARSON? Y / N	DATE	SEXUALLY ACTIVE WITH OTHER THAN SPOUSE? Y / N
ANY PAST/PRESENT HOMOSEXUAL ACTIVITY? Y / N	EVER BEEN ACCUSED OF CHILD/SEXUAL ABUSE? IF YES, EXPLAIN. Y / N			
EVER BEEN ARRESTED? IF YES, EXPLAIN. Y / N				
ANY OPEN/PENDING LEGAL CASES/SITUATIONS? IF YES, EXPLAIN. Y / N				
CURRENTLY ON PROBATION/PAROLE? IF YES, EXPLAIN. Y / N				
PROBATION/PAROLE OFFICER NAME	PROBATION/PAROLE OFFICER PHONE	TIME REMAINING ON PROBATION/PAROLE		
LAWYER NAME	LAWYER PHONE			

APPLICANT NAME (print)

DATE

### SECTION V - PARENTAL DATA

FATHER NAME		CAUSE OF DEATH (IF DECEASED)		
ADDRESS	CITY	STATE	ZIP	
MOTHER NAME		CAUSE OF DEATH (IF DECEASED)		
ADDRESS	CITY	STATE	ZIP	
STEP-FATHER NAME		CAUSE OF DEATH (IF DECEASED)		
ADDRESS	CITY	STATE	ZIP	
STEP-MOTHER NAME		CAUSE OF DEATH (IF DECEASED)		
ADDRESS	CITY	STATE	ZIP	

### SECTION VI - EMERGENCY CONTACTS

CONTACT 1 NAME	RELATIONSHIP TO YOU	DAY PHONE	EVENING PHONE	CELL PHONE
ADDRESS	CITY	STATE	ZIP	
CONTACT 2 NAME	RELATIONSHIP TO YOU	DAY PHONE	EVENING PHONE	CELL PHONE
ADDRESS	CITY	STATE	ZIP	

### SECTION VII - EMPLOYMENT & EDUCATION

CURRENTLY EMPLOYED? IF YES, STATE WHERE EMPLOYED. Y / N		
IF UNEMPLOYED, IS UNEMPLOYMENT RELATED TO SUBSTANCE ABUSE/ADDICTION? Y / N	STATE CURRENT/PRIOR OCCUPATION	
LIST SPECIAL JOB TRAINING OR SKILLS		
LAST FULL GRADE COMPLETED	LIST DEGREES/CERTIFICATIONS	DO YOU WISH TO ATTAIN G.E.D.? Y / N

### SECTION VIII - MEDICAL HISTORY

PAST DISEASES (CIRCLE ANY YOU HAVE EVER HAD)		
MUMPS	SCARLET FEVER	HEART DISEASE
MEASLES	RHEUMATIC FEVER	DIABETES
WHOOPING COUGH	CHICKEN POX	DISCHARGING EARS
ASTHMA	PNEUMONIA	SYPHILIS
HAY FEVER	POLIO	GONORRHEA
DIPHtherIA	CONVULSIONS	HERPES

### SECTION VIII - MEDICAL HISTORY *CONTINUED*

RECENT DISABILITIES (CIRCLE ANY YOU HAVE HAD IN PAST YEAR)

- |                        |                      |                    |
|------------------------|----------------------|--------------------|
| 4 OR MORE COLDS YEARLY | FAINTING SPELLS      | HEARING DIFFICULTY |
| FREQUENT SORE THROAT   | ABDOMINAL PAINS      | TIRE EASILY        |
| POOR VISION            | FREQUENT URINATION   | BREATH SHORTNESS   |
| FREQUENT LEG PAINS     | ALLERGY              | HERNIA (RUPTURE)   |
| DIZZINESS              | PERSISTENT COUGH     | RINGWORM           |
| FREQUENT STIES         | SPEECH DIFFICULTY    | NOSE BLEEDING      |
| DENTAL DEFECTS         | CRIPPLING CONDITIONS | RINGING OF EARS    |
| HEART CONDITION        | TRAUMA               | SEIZURES           |
| OTHER _____            |                      |                    |

RECENT WEIGHT GAIN/LOSS? LBS GAINED/LOST  
Y / N

EVER ATTEMPT SUICIDE? DATE  
Y / N

EVER TESTED FOR TUBERCULOSIS? DATE  
Y / N

HAD A TETANUS SHOT WITHIN LAST 5 YEARS?  
Y / N

DO YOU CURRENTLY HAVE A VENEREAL DISEASE?  
Y / N

ANY REASON TO BELIEVE YOU HAVE AIDS?  
Y / N

LIST NAME, DOSAGE AND AMOUNT TAKEN DAILY OF ANY CURRENTLY PRESCRIBED MEDICATIONS?

LIST ANY MEDICATIONS TO WHICH YOU ARE ALLERGIC.

EVER BEEN HOSPITALIZED FOR PSYCHIATRIC TREATMENT? IF YES, EXPLAIN.  
Y / N

EVER HAD ANY EMOTIONAL UPSETS WHICH REQUIRED A DOCTOR OR PROFESSIONAL COUNSELOR? IF YES, EXPLAIN.  
Y / N

EXPLAIN ANY OTHER MEDICAL ISSUES THAT WE SHOULD BE AWARE OF.

DO YOU HAVE MEDICAL INSURANCE?  
Y / N

NAME OF INSURANCE COMPANY

NAME OF INSURED

POLICY NUMBER

GROUP NUMBER

DOCTOR NAME ADDRESS CITY STATE ZIP

DOCTOR PHONE

### SECTION IX - FINANCIAL RESOURCES

- CIRCLE ANY ITEMS WHICH APPLY TO YOU
- |                                   |  |
|-----------------------------------|--|
| ELIGIBLE FOR UNEMPLOYMENT         | ELIGIBLE FOR HOUSING INCOME FROM SOCIAL SERVICES |
| ELIGIBLE FOR TEMPORARY DISABILITY | CURRENTLY COLLECTING SSI                         |

CURRENTLY RECEIVING ANY FUNDING FROM SOCIAL SERVICES WHICH IS NOT LISTED ABOVE?  
Y / N

DO YOU RECEIVE ANY OTHER INCOME? IF YES, EXPLAIN.  
Y / N

ANY OTHER RESOURCES (IRA, PENSION, SAVINGS/CHECKING ACCOUNTS, 401(K), ETC.)? IF YES, EXPLAIN.  
Y / N

## SECTION X - FINANCIAL SPONSORS

I UNDERSTAND THAT IT COSTS TRANSFORMATION LIFE CENTER, INC. (TLC) MORE THAN \$2,000 PER MONTH FOR EACH RESIDENT IN THE PROGRAM AND THAT I AM BEING ASKED TO CONTRIBUTE ONLY \$1,000 PER MONTH TOWARD THIS COST. I FURTHER UNDERSTAND THAT I WILL BE ASKED, UPON COMPLETION, TO REIMBURSE THE SCHOLARSHIP FUND FOR THE NEXT MAN FOR A MINIMUM OF \$6,000. I WILL ALSO ASSUME FULL RESPONSIBILITY FOR THE TOTAL COST OF ANY EMERGENCY, MEDICAL, DENTAL, OR TRANSPORTATION NEEDS. I FURTHER AGREE TO BRING \$100 APPLICATION FEE. NO DONATED FUNDS OR FEES ARE REFUNDABLE. I ALSO UNDERSTAND THAT THE ACCEPTANCE OF A RESIDENT INTO THE PROGRAM IS BASED UPON A NUMBER OF CRITERIA INCLUDING COMMITTED FINANCIAL SUPPORT. THEREFORE, IF TLC DOES NOT RECEIVE THE FINANCIAL SUPPORT AS COMMITTED, THE RESIDENT MAY NOT BE ALLOWED TO CONTINUE IN THE PROGRAM.

IN SUMMARY, I UNDERSTAND THAT I AM TO PROVIDE TLC WITH:

- \$1,000 PER MONTH TO COVER PROGRAM COST (NONREFUNDABLE).
- REIMBURSEMENT OF THE SCHOLARSHIP FUND FOR THE NEXT MAN OF AT LEAST \$6,000.
- \$100 APPLICATION FEE.

ANY RESIDENT WHO HAS A PAST DUE AMOUNT OVER 30 DAYS WILL BE REQUIRED TO DONATE 50% OF ANY MONIES SENT DIRECTLY TO HIM. TLC RESERVES THE RIGHT TO RETURN TO SENDER EXCESSIVE "CARE PACKAGES" TO ANY RESIDENT WITH A PAST DUE OF OVER 30 DAYS.

SIGNATURE

DATE

SPONSOR NAME

RELATIONSHIP

ADDRESS

CITY

STATE

ZIP

EMAIL

HOME PHONE

WORK PHONE

CELL PHONE

MONTHLY AMOUNT PLEDGED BY SPONSOR

SPONSOR SIGNATURE

AS A SPONSOR, YOU MAY PAY BY CHECK, MONEY ORDER OR CREDIT CARD. PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO "TLC". WRITE THE RESIDENT'S NAME IN THE MEMO AREA. FOR PAYMENTS BY CREDIT CARD, PLEASE FILL OUT THE INFORMATION BELOW.

CREDIT CARD

AMEX    DISCOVER    MC    VISA

ACCOUNT NUMBER

EXPIRATION DATE

AUTOMATICALLY WITHDRAW PLEDGED AMOUNT MONTHLY? IF YES, INDICATE PREFERRED TIMEFRAME (I.E. 15<sup>TH</sup> OF EACH MONTH).

Y / N

DO YOU HAVE MORE THAN 1 SPONSOR? IF YES, MAKE A SEPARATE COPY OF THIS PAGE FOR EACH SPONSOR.

Y / N

TOTAL # OF SPONSOR PAGES

## SECTION XI - LEGAL CONSENTS AND CERTIFICATIONS

INITIAL EACH STATEMENT AFTER YOU HAVE FULLY READ AND UNDERSTOOD THAT STATEMENT

ENTER INITIALS	CONSENT AND CERTIFICATION STATEMENTS
	1. I AGREE THAT I WILL HOLD HARMLESS AND NOT BRING SUIT AGAINST TRANSFORMATION LIFE CENTER, INC. MINISTRIES OR ITS' AGENTS OR EMPLOYEES FOR ANY INJURY, HARM OR OTHER DANGERS WHETHER CAUSED BY ITS' AGENTS, EMPLOYEES OR BY THIRD PARTIES.
	2. I UNDERSTAND THAT TRANSFORMATION LIFE CENTER, INC. MAY BE USING MY TESTIMONY (WRITTEN AND/OR VERBAL), PHOTO, VIDEO (IMAGES), AND/OR AUDIO (VOICE), OF ME FOR ITS MINISTRY USE. I UNDERSTAND THAT TRANSFORMATION LIFE CENTER, INC. WILL BE USING THESE BOTH IN PRIVATE AND PUBLIC (I.E. NEWSLETTER, WEBSITE, STORYBOARD, ETC.). MY SIGNATURE STATES THAT I UNDERSTAND THAT ALL THE ABOVE MATERIAL IS THE PROPERTY OF TRANSFORMATION LIFE CENTER, INC. AND I FREELY GIVE TRANSFORMATION LIFE CENTER, INC. FULL RIGHTS OF IT'S USE.
	3. I FURTHER CONSENT THAT THE AUTHORITIES OF TRANSFORMATION LIFE CENTER, INC MAY PROVIDE FOR EXAMINATION AND/OR DIAGNOSTIC PROCEDURES AND MAY PROVIDE EMERGENCY SURGERY, COUNSELING SERVICES AND/OR MEDICAL OR DENTAL TREATMENT OR ADMINISTRATION OF NECESSARY ANESTHETICS, WHEN IN THE OPINION OF ANY PHYSICIAN OR SURGEON OF GOOD STANDING SUCH EXAMINATION, DIAGNOSTIC OR MEDICAL TREATMENT IS NECESSARY FOR THE MENTAL OR PHYSICAL HEALTH OF THE ABOVE NAMED INDIVIDUAL.
	4. I HEREBY AUTHORIZE TRANSFORMATION LIFE CENTER, INC. TO OBTAIN ANY MEDICAL RECORDS NECESSARY FOR THE SPECIFIC PURPOSE OF TREATMENT WHILE HERE. I UNDERSTAND THAT ANY OF THE RECORDS OBTAINED CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT AND I ALSO UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED BY ME, IN WRITING, AT ANY TIME. (I.E., HOSPITAL, PSYCHOSOCIAL, PSYCHIATRIC, PHYSICIAN, ETC.)
	5. TRANSFORMATION LIFE CENTER, INC. HAS THE PERMISSION TO INTERACT AND/OR RELEASE ANY PERTINENT INFORMATION/PAPERWORK TO FAMILIES, PASTORS, PROBATION, PHYSICIANS, COURTS, AND ANY OTHER PROFESSIONALS THAT WE DEEM APPROPRIATE.
	6. WHILE AT ANY TLC FUNCTION OR OUT ON PASS TLC IS NOT LIABLE FOR MY ACTIONS. I AM SOLELY RESPONSIBLE TO ADHERE TO ALL STATE AND FEDERAL LAWS, AND ALL ASPECTS OF MY TLC COVENANT.
	7. I HAVING READ THE POLICIES AND PROCEDURES OF TRANSFORMATION LIFE CENTER, INC. UNDERSTAND AND HAVE NO QUESTIONS REGARDING THE CONTENTS OF THIS PAPERWORK.
	8. I DO HEREBY CERTIFY THAT ALL THE RECORDED INFORMATION ON THIS APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

BY SIGNING BELOW, I ACKNOWLEDGE THE FOLLOWING IN REGARD TO THE STATEMENTS IN SECTION XI:

- I HAVE FULLY READ EACH OF THE STATEMENTS.
- ANY QUESTIONS I HAD REGARDING THE STATEMENTS HAVE BEEN FULLY ANSWERED.
- I HAVE A FULL UNDERSTANDING OF EACH STATEMENT.
- MY INITIALS BY A STATEMENT INDICATE MY AGREEMENT TO THAT STATEMENT.

SIGNATURE

DATE

## SECTION XII - TREATMENT GOALS

NOTE ALL TREATMENT GOALS THAT YOU WISH TO OBTAIN ON THE FOLLOWING EVALUATION FORM.

DURING YOUR STAY, ADVISORS MAY ADD AREAS TO THIS LIST AS THEY ARE REVEALED.

OUR HOPE IS THAT YOU WILL BE MOTIVATED TO DO THE INTERNAL PERSONAL WORK WHICH WILL LEAD TO YOUR FUTURE SUCCESS IN LIFE. ANYONE CAN COME INTO THIS PROGRAM AND ADHERE TO THE RULES, DO ALL THE HOMEWORK, AND SHOW UP TO CLASSES. EXTERNAL DISCIPLINE IS AN EMPTY SHELL. IT IS ONLY WHEN THE INTERNAL WORK IS DONE THAT TRANSFORMATION TRULY TAKES PLACE.

**CIRCLE YOUR TREATMENT GOALS**

- |                    |               |               |
|--------------------|---------------|---------------|
| ADDICTION          | ANGER         | DIVORCE       |
| DEPRESSION         | DISCIPLINE    | HATE          |
| FORGIVENESS        | GOSSIP        | LYING         |
| LAZINESS           | LISTENER      | SOCIAL SKILLS |
| SELFISHNESS        | SELF WORTH    | PATIENCE      |
| WORRY              | SENSITIVITY   | BITTERNESS    |
| HOMOSEXUALITY      | COMMUNICATION | FAITH         |
| LUST               | ANXIETY       | GRATITUDE     |
| TEMPER             | CONTROL       | MANIPULATION  |
| TRUST              | FEAR          | SUBMISSION    |
| HEALTHY BOUNDARIES | OTHER _____   |               |