



2130 SE 59<sup>th</sup> Oklahoma City, Oklahoma 73129  
 P.O. Box 2896, Oklahoma City, OK, 73101  
 Phone: (405) 236-3349 – Fax: (405) 232-5871  
 Please email to Bobby@huminc.org

## APPLICATION FOR MEN

Date:		Expected Release Date:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Facility at which incarcerated:			Phone No.		
Case Manager:		DOC #	SS#	--	--
Last Name:		First Name:		Middle Initial:	
Date of Birth -- --	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
No. of Children and Ages:					
Would you be homeless if it wasn't for Hand Up Ministry? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>EMPLOYMENT</b>					
Last Place of employment prior to incarceration:					
Type of Work you have done:					
Special Training:					
Do you have a valid Drivers License? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you own a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>PROGRAMS COMPLETED: (List all programs completed while incarcerated)</b>					
<b>CRIMINAL HISTORY</b>					
Current Offense:			Sentence:		
Age First Arrested:			Total Times Incarcerated:		
Have you ever been arrested of a sex related crime? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Number of disciplinary write ups you have had during present incarceration:					
<b>SUBSTANCE ABUSE HISTORY</b>					
Is your current offense drug related? <input type="checkbox"/> Yes <input type="checkbox"/> No			Drug of Choice:		
Have you ever been in treatment for substance abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>MEDICAL HISTORY</b>					
Do you have any physical problems? <input type="checkbox"/> No <input type="checkbox"/> Yes What?					
Are you on any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes What?					
Do you have any mental health problems? <input type="checkbox"/> No <input type="checkbox"/> Yes What?					
Have you ever attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>RELIGIOUS AFFILIATION</b>					
Religious Preference (if any):					
You <b>must</b> also send us a copy of your <b>Birth Certificate and Social Security card</b> with your application. We can't accept anyone without these important documents. You will bring the originals with you.					

Hand Up Ministries, Inc reserves the right to refuse anyone we feel will not be faithful to work the program or be a negative influence on others or distract them from their commitment to the program, or for any other reason that may cause disharmony. We encourage each client to attend the church of their choice.

My signature below certifies that I am requesting to enter the Hand Up Ministries' Clean Living Program and that all my answers on this application are true and correct. **Please note that this is a program, not just a living arrangement. You will be required to follow all aspects of this program.**

\_\_\_\_\_  
Signature



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**SOCIAL HISTORY**

Case Manager: \_\_\_\_\_

Case Manager's Phone: \_\_\_\_\_

Who referred you?

- Attorney: \_\_\_\_\_
- Probation/Parole: \_\_\_\_\_
- Pre-Sentence Investigator: \_\_\_\_\_
- Judge: \_\_\_\_\_
- Court: \_\_\_\_\_
- District Attorney: \_\_\_\_\_
- Drug Court Admin: \_\_\_\_\_
- Other: \_\_\_\_\_

**Presenting Problem** (Please explain why are you incarcerated?)

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**History of Presenting Problem** (Tell us how you crossed the line.)

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**Emergency Notification:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: (    )    -    \_\_\_\_\_



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**FAMILY SYSTEM - SOCIAL & PRESENT LIFE SITUATION**

Current Marital Status?  Single  Married Spouse's Name: \_\_\_\_\_  
 Divorced  Separated How long? \_\_\_\_\_

How many times have you been married? \_\_\_\_\_ How many times have you been divorced? \_\_\_\_\_

How many live-in relationships have you had? \_\_\_\_\_ How many children do you have? \_\_\_\_\_

<u>Child's Name</u>	<u>Age</u>	<u>Gender</u>	<u>Residence</u>
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____

Do you pay child support?  No  Yes How much? Are you current?  Yes  No

Do any of your children have problems in any of the following areas?

- Behavioral  Mental Health  Emotional  Alcohol
- Drugs  Physical  Educational  Other

Your usual living arrangements? \_\_\_\_\_

Father's Name: \_\_\_\_\_ Father's Age: \_\_\_\_\_  
 Father's Occupation: \_\_\_\_\_ Health:  Excellent  Good  Fair  Bad  
 Relationship with Father:  Excellent  Good  Fair  Bad

Mother's Name: \_\_\_\_\_ Mother's Age: \_\_\_\_\_  
 Mother's Occupation: \_\_\_\_\_ Health:  Excellent  Good  Fair  Bad

Relationship with Mother:  Excellent  Good  Fair  Bad

<u>Sibling's Name(s)</u>	<u>Age</u>	<u>Gender</u>	<u>Older/Younger</u>	<u>Relationship</u>
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Older <input type="checkbox"/> Younger	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Bad
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Older <input type="checkbox"/> Younger	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Bad
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Older <input type="checkbox"/> Younger	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Bad
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Older <input type="checkbox"/> Younger	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Bad
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Older <input type="checkbox"/> Younger	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Bad
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Older <input type="checkbox"/> Younger	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Bad

Do either of your parents or any of your brothers or sisters have problems with:

- Alcohol  Drugs  Mental Health

Have you ever been physically, emotionally, or sexually abused by either of your parents?  Yes  No

Have you ever been physically, emotionally, or sexually abused by any of your siblings?  Yes  No



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**PERSONAL & CULTURAL (GENERAL)**

Military History: Branch of Service \_\_\_\_\_  
Discharge:  Honorable  Dishonorable

Race:  Caucasian  African American  Native American (tribe) \_\_\_\_\_  
 Alaskan Native  Hispanic  Asia  Other \_\_\_\_\_  
Religious Preference:  Protestant  Catholic  Jewish  Islamic  None

What are your Strengths:  
\_\_\_\_\_

What are your Weaknesses:  
\_\_\_\_\_

What is your Recreation/leisure history:  
\_\_\_\_\_

What are your Expectations of this agency:  
\_\_\_\_\_

**EDUCATION**

Education completed:  Elementary School  Middle School  High School  
 Some College  GED (Highest Grade Completed \_\_\_\_\_)  
Major: \_\_\_\_\_ No. Credit Hours: \_\_\_\_\_

Difficulties with school: \_\_\_\_\_

**Occupational**

Current Occupation while incarcerated: \_\_\_\_\_

Last Employer: \_\_\_\_\_

Length of time you were with this employer: \_\_\_\_\_

Type of work you usually perform: \_\_\_\_\_

Special skills or trade: \_\_\_\_\_



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**FINANCIAL**

Do you have disabilities that will limit or prevent your employment? Yes  No

If yes, how will you pay your program fees?  SSDI  VA Disability  Retired  Annuity  Trust  
 Other \_\_\_\_\_

How many people will depend on you for the majority of their food, shelter, etc.? \_\_\_\_\_

Do you have any income or other financial resources?  Yes  No

If Yes, Source: \_\_\_\_\_ Amount: \_\_\_\_\_ per Hour / Week / Month (Circle one)

Will someone contribute to your support in any way?  Yes  No

Who and What? \_\_\_\_\_

Attach your previous 3 months income statements or pay stubs (if any)

**CLINICAL TREATMENT HISTORY**

Do any of the following apply to you?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Fainting Spells            | <input type="checkbox"/> Stomach Trouble     |
| <input type="checkbox"/> Bowel Disturbances   | <input type="checkbox"/> Insomnia                   | <input type="checkbox"/> Take Sedatives      |
| <input type="checkbox"/> Feel Tense           | <input type="checkbox"/> Tremors                    | <input type="checkbox"/> Suicidal Ideas      |
| <input type="checkbox"/> Unable to Relax      | <input type="checkbox"/> Unable to have a good time | <input type="checkbox"/> Can't make friends  |
| <input type="checkbox"/> Can't make decisions | <input type="checkbox"/> Inferiority feelings       | <input type="checkbox"/> Financial problems  |
| <input type="checkbox"/> Over ambitious       | <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Palpitations        |
| <input type="checkbox"/> No appetite          | <input type="checkbox"/> Fatigue                    | <input type="checkbox"/> Nightmares          |
| <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Feel panicky               | <input type="checkbox"/> Depressed           |
| <input type="checkbox"/> Drugs                | <input type="checkbox"/> Sexual problems            | <input type="checkbox"/> Shy with people     |
| <input type="checkbox"/> Feel lonely          | <input type="checkbox"/> Can't keep a job           | <input type="checkbox"/> Home conditions bad |
| <input type="checkbox"/> Don't like weekends  | <input type="checkbox"/> Don't like vacations       |  |

Do you have any chronic medical problems?  Yes  No  
 What? \_\_\_\_\_

Are you taking any prescribed medications?  Yes  No

<u>Medication</u>	<u>Strength/Dosage</u>	<u>How Long</u>	<u>Benefits</u>	<u>Side Effects</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever been hospitalized?  Yes  No

When: \_\_\_\_\_ Where: \_\_\_\_\_ Problem: \_\_\_\_\_  
 When: \_\_\_\_\_ Where: \_\_\_\_\_ Problem: \_\_\_\_\_



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**SEXUAL HISTORY**

Have you ever been diagnosed and/or treated for a sexually transmitted disease?  Yes  No

Have you ever been tested for HIV/AIDS?  Yes  No      Results?  Positive  Negative

Do you consider yourself:  Homosexual (Gay)  Bisexual    or     Heterosexual (Straight)?

**MENTAL HEALTH HISTORY**

Have you ever been treated for an emotional/mental health problem?  Yes  No

When: \_\_\_\_\_ Where: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Physician: \_\_\_\_\_

Has any one in your family even been treated for emotional/mental health problems?  Yes  No

Who: \_\_\_\_\_ When: \_\_\_\_\_ Where: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Physician: \_\_\_\_\_

Have you experienced any of the following?

- |   |                                       |                                   |                                  |                                   |                               |
|---|---------------------------------------|-----------------------------------|----------------------------------|-----------------------------------|-------------------------------|
| Depression  | <input type="checkbox"/> Past 30 days | <input type="checkbox"/> Lifetime | <input type="checkbox"/> Serious | <input type="checkbox"/> Moderate | <input type="checkbox"/> Mild |
| Anxiety or Tension  | <input type="checkbox"/> Past 30 days | <input type="checkbox"/> Lifetime | <input type="checkbox"/> Serious | <input type="checkbox"/> Moderate | <input type="checkbox"/> Mild |
| Hallucination (excluding drugs)   | <input type="checkbox"/> Past 30 days | <input type="checkbox"/> Lifetime | <input type="checkbox"/> Serious | <input type="checkbox"/> Moderate | <input type="checkbox"/> Mild |
| Trouble Understanding   | <input type="checkbox"/> Past 30 days | <input type="checkbox"/> Lifetime | <input type="checkbox"/> Serious | <input type="checkbox"/> Moderate | <input type="checkbox"/> Mild |
| Trouble Concentrating/Remembering   | <input type="checkbox"/> Past 30 days | <input type="checkbox"/> Lifetime | <input type="checkbox"/> Serious | <input type="checkbox"/> Moderate | <input type="checkbox"/> Mild |
| Trouble Controlling Violent Behavior<br>(including periods of rage or violence) | <input type="checkbox"/> Past 30 days | <input type="checkbox"/> Lifetime | <input type="checkbox"/> Serious | <input type="checkbox"/> Moderate | <input type="checkbox"/> Mild |
| Thoughts of Suicide   | <input type="checkbox"/> Past 30 days | <input type="checkbox"/> Lifetime | <input type="checkbox"/> Serious | <input type="checkbox"/> Moderate | <input type="checkbox"/> Mild |

Attempted Suicide

Explain:      When \_\_\_\_\_      Where \_\_\_\_\_  
                   Method \_\_\_\_\_      Drugs involved?  Yes  No

Homicidal thought and History

Explain: \_\_\_\_\_

Have you been prescribed medication for any psychological/emotional problem?  Yes  No

Physician: \_\_\_\_\_



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**DOMESTIC VIOLENCE/SEXUAL ASSAULT**

Have you ever had feelings of uncontrollable rage?  Yes  No

Have you had any thoughts about harming others?  Yes  No

Have you ever had trouble controlling your impulses?  Yes  No

As an adult, have you been involved in fights?  Yes  No

Were you ever arrested for fighting or for other violent behavior?  Yes  No

If any of the above are answered YES, answer the following:

What were the circumstances of the violent act? \_\_\_\_\_  
\_\_\_\_\_

When did they occur? \_\_\_\_\_

Who was involved? \_\_\_\_\_

How did you feel about this? \_\_\_\_\_

Did the behavior involve substance abuse?  Yes  No

What was the effect on the victim? \_\_\_\_\_

What happened to you as a result? \_\_\_\_\_

Were you arrested?  Yes  No    How much time did you serve? \_\_\_\_\_

Have you ever been accused of rape or sexual crime?  Yes  No

If yes, was your victim Male or Female? \_\_\_\_\_

Have you ever been accused of domestic violence?  Yes  No

Have you ever had a Victim's Protective Order against you?  Yes  No



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**LEGAL CRIMINAL RECORD**

How many times in your life have you been arrested and charged with the following?

	<u>No. of Arrests</u>	<u>Dates</u>
Public Drunk	_____	_____
DUI	_____	_____
DWI	_____	_____
APC	_____	_____
DUS	_____	_____
Shoplifting/vandalism/theft	_____	_____
Parole/probation violation	_____	_____
Drug charges	_____	_____
Forgery	_____	_____
Weapons offense	_____	_____
Larceny	_____	_____
Burglary	_____	_____
Breaking & Entering	_____	_____
Robbery	_____	_____
Assault	_____	_____
Arson	_____	_____
Rape/sex related crimes	_____	_____
Homicide/manslaughter	_____	_____
Prostitution	_____	_____
Contempt of court	_____	_____
Disorderly conduct/vagrancy	_____	_____
Major driving violations	_____	_____
Other	_____	_____

Have you engaged in illegal activities for profit?  Yes  No

What is your explanation of legal problems

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**Gang History**

Gang Affiliation/Status \_\_\_\_\_ Age on joining \_\_\_\_\_ Leaving \_\_\_\_\_

Motivation for joining \_\_\_\_\_ Motivation for leaving \_\_\_\_\_

Violence with gang \_\_\_\_\_

Sexual offenses with gang \_\_\_\_\_

What Programs have you completed while incarcerated: \_\_\_\_\_

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**SUBSTANCE ABUSE HISTORY**

<u>Substance</u>	<u>Age first use</u>	<u>Date last use</u>	<u>Frequency</u>	<u>How used</u>
Alcohol	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
Alcohol to intoxication	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
Heroin	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
Methadone	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
Painkillers	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
Sleeping pills	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
Valium, Librium, Zanax	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
Cocaine/Crack	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
Crank/Methamphetamine	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
THC (marijuana)	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
Hallucinogens	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
Inhalants	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
PCP	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
More than 1 substance at a time	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral
Other	_____	_____	_____	<input type="checkbox"/> IV <input type="checkbox"/> Snort <input type="checkbox"/> Smoke <input type="checkbox"/> Oral

Drug of Choice: \_\_\_\_\_

Have you ever experienced DTs:  Yes  No      Drug Overdose?  Yes  No

Where do you usually drink or use drugs? \_\_\_\_\_ Do you ever drink or use drugs alone?  Yes  No

Have you ever drank or used drugs more than you intended?  Yes  No

Have you ever been treated for alcohol/drug abuse?  Yes  No

When: \_\_\_\_\_ Where: \_\_\_\_\_ Complete:  Yes  No Length: \_\_\_\_\_

When: \_\_\_\_\_ Where: \_\_\_\_\_ Complete:  Yes  No Length: \_\_\_\_\_

**Tobacco Usage:** Check all that apply to you.

I am a non-smoker    I smoke cigarettes    I smoke a pipe    I dip snuff    I chew tobacco





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## Program Rules

### EMPLOYMENT

1. I agree that I will make every attempt to find and maintain permanent employment while in the program of Hand Up Ministries, and accept ministry staff's input in my job search..
2. While seeking employment, I agree to present verification of **at least five** job interviews per week to Hand Up Ministries.
3. During times that I am unemployed, I will participate in job search, or assignment of work to be done at the ministry each day. **Monday thru Friday I will be in the office at 8:00 AM. signed in, bathed and groomed ready for work** or planning and assignments for the day.
4. I agree that I **will not quit** my job before discussing it with my Hand Up Ministries Counselor and having another job.
5. I understand that I am to obtain work as soon as possible and that my program and fees, may be as follows:
  - A) \$140.00 per week, depending on resources requested and available.
  - B) \$115.00 per week, depending on resources requested and available.
  - C) \$105.00 per week, depending on shared resources option, if available.

I understand that Hand Up Ministries will work with me on paying program fees out over an agreed upon time while paying current fees with the goal of being ahead **at least** one week.

### TRANSPORTATION

1. I understand that if I do not have transportation to work, Hand Up Ministries will assist with transportation to work. I also understand that there will be a nominal fee **per one way trip** for each trip I utilize Hand Up Ministries transportation.
2. I understand that there will be a flat rate charge for any **court related out of county** transportation.
3. I agree to present a request for transportation needs to the office of Hand Up Ministries at least **12 hours** before the time transportation is needed.
4. I agree that any vehicle that I bring to Hand Up Ministries will be properly registered in my name and display current motor vehicle tags. A copy of the current registration and title will be given to Hand Up Ministries.
5. I agree that any vehicle that I bring to Hand Up Ministries will be maintained in proper running condition and that any cleaning or mechanical work to be performed on any vehicle will be performed in **designated areas only**.



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## FINANCIAL MANAGEMENT

1. I agree that my pay check will be turned into Hand Up Ministries each week and deposited in a trust account in my name until my trust balance reaches \$500.00 or more. **Should my balance DROP BELOW \$10.00 I will be placed back on Money Management.**
2. I agree to participate with a financial counselor at Hand Up Ministries to prepare a financial budget based on my income.
3. I agree to accept an amount agreed upon with my financial counselor for personal cash expenditures that will be disbursed once each week..
4. I agree that **I will not borrow money** from other residents or staff of Hand Up Ministries.
5. I understand that this financial arrangement will remain in effect until such time as **Hand Up Ministries determines** that I am capable of handling my own financial matters.

## LIVING QUARTERS

1. I agree that my living quarters will be kept neat and clean at all times.
2. I agree that my living quarters may be inspected at any time **without notice** by Hand Up Ministries.
3. I agree that if my living quarters are found to be less than neat and clean, I will make the necessary improvements within **24 hours** at which time the living quarters will be re-inspected.
4. I agree that **private cable lines** installed in my living quarters will be at my own expense and all cable service will be basic cable only.
5. I agree that if I possess a computer in my living quarters that has a modem, the carrier for internet services will be by a carrier approved by Hand Up Ministries only.
6. I agree and understand that **NO WOMEN OR CHILDREN** are allowed in any living quarters at any time.
7. **I agree to keep my voice, radio, and television volume at a level that will not disturb my roommate or my neighbors.**



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## PERSONAL BELONGINGS

1. I agree that all electrical appliances will be presented for inspection and identification before being utilized in my apartment.
2. I agree that if on inspection of my living quarters, any electrical appliance is found which is not tagged as passing inspection, that appliance will be removed from my living quarters and may be retrieved from the office only after it has been inspected.
3. I agree that any appliance that does not pass electrical inspection will remain in the office to be properly disposed of.
4. **I agree that Hand Up Ministries is not responsible for my personal belongings.**
5. I agree that upon my leaving Hand Up Ministries, I will take all of my personal belongings.
6. I agree that any personal belongings left at Hand Up Ministries after my departure, will be disposed of within thirty (30) days by Hand Up Ministries.

## MEDICAL AND/OR PSYCHOLOGICAL

1. I agree to reveal to Hand Up Ministries any medical and/or psychological problems that I might currently have or that might develop during my participation in the Hand Up Ministries Program.
2. I agree to release to Hand Up Ministries any and all medical and/or psychological records.
3. I agree that any narcotic or psychotropic medications that are prescribed to me by a licensed physician will be turned over to Hand Up Ministries and will be placed in the office safe.
4. I agree to participate in any medical and/or psychological program deemed necessary by Staff.



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## ALCOHOL AND DRUGS

1. I agree that NO ALCOHOL OR ILLEGAL DRUGS will be used or possessed by me while participating in the Hand Up Ministries Program.
2. I agree that if any staff member at the direction of the executive director, requests a drug/alcohol test, I will submit to an observed urine specimen immediately and without argument or comment.
3. I agree that the urine specimen will be collected by authorized staff only, residents with positive UAs are charged \$10.00 for the test, negative UAs are not charged.
4. I agree that drug/alcohol tests will be requested on a random and regular basis.
5. I agree that if I refuse to submit to or falsify a drug/alcohol test that the test **will be considered positive.**
6. I agree that any positive drug/alcohol test will result in **IMMEDIATE ACTION** by staff to recommend corrective action, or removal from the Hand Up Ministries program.
7. I agree that if I am aware of the presence of alcohol/drugs on the premises of Hand up Ministries, I will notify authorized staff immediately.

## VISITORS

1. **I agree that all visitors will be met in the common area only.**
2. I agree that all visitors will register with the office before each visit.
3. I agree that if any visitor is deemed inappropriate by authorized staff of Hand Up Ministries, that the visitor will leave the premises immediately.

## COMMON AREAS (eating area, meeting rooms, offices, yard, etc.)

1. I agree that all common areas are to be kept clean and that I will remove my trash and cigarette butts after each use of a common area.
2. I agree that when entering a common area I will be bathed and dressed appropriately.
3. I agree that if I am not properly attired and/or maintaining clean hygiene, I will be required to leave the area.
4. I agree that if at any time it is determined by Hand Up Ministries staff that I am not acting in an appropriate manner, I will leave the common area without further disturbance.



2130 SE 59<sup>th</sup> Oklahoma City, Oklahoma 73129  
P.O. Box 2896, Oklahoma City, OK, 73101  
Phone: (405) 236-3349 – Fax: (405) 232-5871  
Please email to Bobby@huminc.org

## PROGRAM SERVICES

1. I agree to participate in an evaluation of my needs to be performed by an assigned counselor.
2. I agree to participate in any program that my counselor deems appropriate to meet my identified needs.
3. **I agree to participate in Training classes on Sunday night each week at 7:00pm at Hand Up Ministries.**
4. I agree to participate in the at least one additional class held weekly at Hand Up Ministries as designated by my counselor.

## OTHER RULES

1. I agree to participate in at least eight (8) hours of community service each month at a location designated by Hand Up Ministries.
2. I agree that I will not participate in cursing, vulgar and/or suggestive language or gestures, or rude or negative behaviors.
3. I agree that I will not wear any article of clothing that displays any vulgar and/or suggestive language or picture, and/or that is vulgar or suggestive in style, and/or that is related to any gang.
4. I agree that there will be no violence or threats of violence made by me.
5. I agree that I will not possess any guns or any illegal weapons while on the property of Hand Up Ministries.
6. I agree to protect the privacy of each member in the Hand Up Ministries Program. I agree that anything that is said in any group meeting will be kept in strictest confidence and will not be discussed with anyone outside of the Hand Up Ministries staff.
7. I agree to have my photograph taken by Hand Up Ministries and that the photograph along with my name and personal testimony may be used in advertising by Hand Up Ministries in Hand Up Ministries newsletters only.
8. I understand that any changes to these Rules must be submitted in writing and signed by both the participant and an authorized representative of Hand Up Ministries.
9. **I agree that I will adhere to an 11:00 PM curfew on Sunday thru Thursday and 12:00 AM curfew on Friday and Saturday. If I am to be out past the curfew I will notify the staff.**
10. I understand and agree that if I fail to return to Hand Up Ministries each and every night, and that my belongings will be removed from my room the next morning and I will be discharged from Hand Up Ministries immediately. **I understand and acknowledge this Application is not a residential lease and my expulsion from the program may be immediate.** If a need arises that requires me to be absent overnight, arrangements will be made with the staff prior to my leaving Hand Up Ministries, **and sign out in the overnight sign out log.**



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**Print Your Full Name**

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**Date of Birth**

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**Soc. Sec. Number**

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**Sign Your Full Name**

---

**Date**

---

**Witness Signature**

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**Date**