LIVE-IN PROGRAM APPLICATION Printable

YOUR FULL NAME

First Name Middle Name Last Name

CURRENT ADDRESS

Street Address

City State / Province

Postal / Zip Code

CONTACT PHONE NUMBER

Please enter a valid phone number.

EMAIL ADDRESS

example@example.com

GENDER

MALE
FEMALE
NON BINARY

SELECT CENTRE YOU WOULD LIKE TO APPLY TO

WINNIPEG MEN
THUNDER BAY MEN
THUNDER BAY WOMAN
BRANDON WOMAN
STEINBACH MEN
FLIN FLON MEN

DATE OF BIRTH

Year Month Day

SOCIAL INSURANCE NUMBER

Please enter a valid SIN #

HOW DID YOU HEAR ABOUT ATCCC? PLEASE GIVE NAME OF INDIVIDUALS, AGENCIES OR GROUPS:

EMERGENCY CONTACT

First Name Last Name

EMERGENCY CONTACT PHONE NUMBER

Please enter a valid phone number.

THEIR RELATIONSHIP TO YOU:

MARITAL STATUS

SINGLE
MARRIED
COMMON-LAW
SEPERATED
DIVORCED

NAME OF SPOUSE

First Name   Last Name

SPOUSE PHONE NUMBER

Please enter a valid phone number.

DOES YOUR SPOUSE SUPPORT YOU COMING INTO THE PROGRAM?

YES
NO

WHAT IS THE GENERAL CONDITION OF YOUR HEALTH?

DO YOU HAVE A HEALTH CARD OR HEALTH INSURANCE?

YES
NO

PLEASE INPUT YOUR HEALTH CARD NUMBER

HAVE YOU EVER BEEN TREATED FOR AIDS?

YES

NO

HAVE YOU RECENTLY TESTED POSITIVE FOR ANY COMMUNICABLE DISEASES?

YES

NO

ARE YOU SEEING A MEDICAL DOCTOR FOR ANY REASON?

YES

NO

PLEASE GIVE A REASON FOR SEEING A MEDICAL DOCTOR:

NAME OF PHYSICIAN

First Name Last Name

PHYSICIAN'S OFFICE ADDRESS

Street Address

City State / Province

Postal / Zip Code Country

PHYSICIAN'S CONTACT PHONE NUMBER

Please enter a valid phone number.

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS?

YES

NO

PLEASE GIVE US MORE DETAILS:

HOW LONG HAVE YOU BEEN TAKING MEDICATION FOR? HOW DO YOU PLAN TO PAY FOR YOUR MEDICATION WHILE YOU ARE IN OUR PROGRAM? WHY DO YOU TAKE THIS MEDICATION?

DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT WOULD HINDER YOU FROM DOING NORMAL MANUAL LABOUR?

YES

NO

PLEASE GIVE US MORE DETAILS:

DO YOU REQUIRE A DOCTOR PRESCRIBED DIET?

YES

NO

DO YOU HAVE ANY ALLERGIES?

YES

NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE HIGH BLOOD PRESSURE?

YES

NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE CANCER?

YES

NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE ASTHMA?

YES

NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE DIABETES?

YES

NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE ANY HEART PROBLEMS?

YES

NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE EPILEPSY?

YES
NO

PLEASE GIVE US MORE DETAILS:

HAVE YOU EVER, OR ARE YOU NOW RECEIVING PSYCHIATRIC TREATMENT?

YES
NO

PLEASE GIVE US MORE DETAILS:

HAVE YOU EVER BEEN CONVICTED OF ANY CRIMES?

YES
NO

PLEASE GIVE US MORE DETAILS:

ARE YOU CURRENTLY IN JAIL?

YES

NO

PLEASE GIVE US MORE DETAILS ABOUT RELEASE DATE AND THE NAME OF INSTITUTION:

ARE YOU ON PROBATION OR PAROLE?

YES

NO

PROBATION/PAROLE OFFICER'S NAME

First Name Last Name

PROBATION/PAROLE OFFICER'S PHONE NUMBER

Please enter a valid phone number.

PROBATION/PAROLE OFFICE ADDRESS

Street Address

City State / Province

Postal / Zip Code

PLEASE GIVE US DETAILS ABOUT REPORTING METHODS:

LAWYERS NAME

First Name Last Name

LAWYERS PHONE NUMBER

Please enter a valid phone number.

LAWYERS OFFICE ADDRESS

Street Address

City State / Province

Postal / Zip Code Country

DO YOU HAVE ANY UPCOMING COURT APPEARANCES?

YES

NO

NEXT UPCOMING COURT APPEARANCE

Year Month Day Hour Minutes

ARE YOU AWARE OF ANY WARRANTS FOR YOUR ARREST IN ANY PROVINCE OF CANADA?

YES

NO

ARE YOU ON A DISABILITY PENSION OR OTHER PENSION CURRENTLY?

YES

NO

PLEASE GIVE DETAILS:

HOW MUCH MONEY DO YOU COLLECT? HOW OFTEN DO YOU COLLECT?

DO YOU HAVE OUTSTANDING DEBTS OR FINES?

YES

NO

PLEASE GIVE DETAILS:

HOW DO YOU PLAN TO PAY THIS OFF?

ARE THERE ANY OTHER FINANCIAL MATTERS WE SHOULD BE MADE AWARE OF?

YES

NO

PLEASE GIVE DETAILS:

ARE YOU SELLING A HOUSE, CAR OR ANY INVOLVED WITH ANY CIVIL LEGAL ACTIONS REGARDING CLAIMS?

DO YOU UNDERSTAND THAT ATCCC IS A CHRISTIAN DISCIPLESHIP PROGRAM AND THAT THERE ARE NO ALTERNATIVE RECOVERY TRACKS WITHIN OUR LONG TERM LIVE-IN PROGRAM?

YES

NO

WHY DO YOU WISH TO ENTER INTO THIS PROGRAM?

WHAT IS YOUR RELIGIOUS PREFERENCE OR DENOMINATION?

HAVE YOU EVER BEEN TO ANOTHER ATCCC LIVE-IN PROGRAM BEFORE?

YES

NO

PLEASE STATE WHICH ATCCC PROGRAM AND HOW LONG YOU RESIDED THERE?

DO YOU FLUENTLY READ, WRITE AND SPEAK ENGLISH?

YES

NO

PLEASE EXPLAIN:

STATE LAST GRADE/POST SECONDARY SCHOOL/TRAINING COMPLETED

HAVE YOU READ THE PROGRAM MANUAL IN ITS ENTIRETY?

YES

NO

DO YOU UNDERSTAND THAT THE PROGRAM IS TWELVE (12) MONTHS MINIMUM?

YES

NO

ARE YOU WILLING TO OBEY THE RULES IN THEIR ENTIRETY?

YES

NO

PLEASE COMMENT ON HOW YOU FEEL ABOUT OUR RULES:

DO YOU SMOKE?

YES

NO

DO YOU UNDERSTAND THAT OUR APPROACH IS COLD TURKEY?

YES

NO

LIVE-IN PROGRAM APPLICATION

This application form must be filled out and signed by the applicant only. if you do not know the answer, please put "n/a" (not applicable). If you require assistance, please don't hesitate to call our main office line.

DO YOU CONSIDER YOURSELF TO BE AN ADDICT?

YES

NO

WHAT IS IT THAT YOU STRUGGLE WITH SPECIFICALLY?

By signing below, you declare that all information on this application form is accurate to the best of your knowledge. Any misleading information may jeopardize the application process.

Signature

Date

Month Day Year