Resident Application

1133 S Edwin C Moses Blvd.
Suite 384
Dayton, Oh 45417
937-898-7811

The Oasis House Residential Program aims to provide female survivors of human trafficking with safe, transitional housing opportunities in order to provide a stable home environment, accompanied by services focused on developing life and occupational skills to allow survivors to overcome their individual traumas. The Program is designed to encourage and support additional mental health, substance abuse, and physical health treatment to allow survivors to realize their full potential.

The Residential Program is designed to be longer in term, if necessary, based on the individual's needs. Please provide a **2-page letter** stating why you want to be a part of the Oasis House's housing program. During the Residential Program, residents will receive individual counseling, referral services for medical treatment, regular group meetings with other survivors, and spiritual counseling.

The resident may be terminated form the program at any time if the resident is not participating in required activities, is not making sufficient progress towards successful completion of the program, or fails to comply with the Housing Rules and Regulations.

The following are the **minimum eligibility requirements** for a resident to be considered for the Oasis House Residential Program:

- Female
- Over the age of 18
- Not the current custodial parent or guardian for any children
- Able to provide self-care and self-administer medication; No needs for handicapped-accessible housing; No medical conditions which warrant significant treatment and/or intervention
- Able to climb stairs
- Mentally capable of processing new information; capable of verbal and written communication
- Mentally and emotionally stable; no reported suicide attempts in three (3) months; No antipsychotic medications
- Sober for at least thirty (30) days
- Not a registered sex offender
- Oasis House is **not** a sober living facility

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A staff member of Oasis House has read through and discussed with me the Residential Program requirements. I understand that if I agree to participate in the program, Oasis House staff will work with me to put together an individualized recovery program that identifies and obtains the services that meet my needs, whether those services be provided by Oasis House or a third party. I also understand that no specific outcome can be guaranteed.

I understand that any services extended to me by Oasis House or a third-party provider requires my cooperation. By signing this application, I agree that I will comply with directives of the individualized recovery program, and will attend and participate in evaluations and assessments for purposes of treatment, individualized therapy, and growth.

I have been provided a copy of the Residential Program No-Tolerance Policy and Code of Conduct. By signing below, I have reviewed the Oasis House No-Tolerance Policy and Code of Conduct and agree that if I am accepted into the Program I will agree and sign

By signing below, I am committing to the residential program for at least two years.

____
Date

______________________________________ ______________________________________
Applicant Signature Witness Signature

____
Applicant Printed Name

I understand that Oasis House regularly evaluates the effectiveness of their programs and services. I am **GRANTING / NOT GRANTING (circle one)** Oasis House permission to use my Residential Application, Intake Form(s), and Follow-Up interviews to use in evaluation and development of Oasis House's current programs.

I recognize that my information will remain confidential at all times, and if I decide to NOT GRANT or later REVOKE permission to use my information, it will in no way affect my application, admission to, or participation in the Residential Program.

______________________________________ _______________________
Signature Date

Date of Application: ______________________
Name of person assisting with application: ____
Release date from current program:_______________________________________

I. Personal Information

Name: ____________________________ Date of Birth: ___________ Age: ________

Maiden Name: ______________________________

Current Address: _______________________________________ City: ____________________________

County: _______________________________________ State: ____________ Zip: _______________

Phone #: _____________________ Cell #: ___________________ E-mail: ______________________

Race: ☐Caucasian ☐African American ☐Asian American ☐Hispanic ☐Other

Do you have a copy of your birth certificate? ☐YES ☐NO

Do you have a driver's license or state ID? ☐YES ☐NO

In case of an emergency, whom should we contact?

Name ____

Relationship _____________________________ Phone Number ___________________________

Address ____ State _________ Zip __________

II. Family History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Name of current significant other (full name): ____

Are you: ☐ Dating ☐ Engaged ☐Married Length of Relationship: _________________

Is your significant other: ☐ Supportive ☐ Non-Supportive

Do you have any children? ☐ YES ☐ NO

Name of Child	Age	Custody Arrangement

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Do you currently have visitation rights with any of your children? ☐ YES ☐ NO

Please identify which child(ren) have visitation rights and the location you currently visit with your child(ren): ____

____

III. Education History

What is the highest grade you have completed? ☐High School Diploma ☐GED
☐Some College ☐ Associates ☐ Bachelors

Have you received vocational training? ☐ YES ☐ NO

Are you currently taking any educational classes? ☐ YES ☐ NO

IV. Substance Abuse History

Please indicate your usages of the following substances:

Cigarettes	☐Still using	☐Sober since ____________
Alcohol	☐Still using	☐Sober since ____________
Prescription Meds	☐Still using	☐Sober since ____________
Illegal Drugs	☐Still using	☐Sober since ____________

Are you willing to limit smoking to outside the residential facilities? ☐YES ☐NO

Are you willing to be stop using alcohol for the duration of your stay? ☐YES ☐NO

Are you willing to stop using drugs (other than verified prescriptions) for the duration of your stay? ☐YES ☐NO

Have you ever drunk alcohol to excess? ☐YES ☐NO

Have you ever overdosed on legal substances (prescription medication)? ☐YES ☐N O

Have you ever overdosed on illegal substances? ☐YES ☐NO

Do you believe you are addicted to any substances? ☐YES ☐NO

What is/are your drug(s) of choice?

____

How old were you when you started using?

Cigarettes ___________

Alcohol ___________

Prescription Meds ___________

Illegal Drugs ___________

Do alcohol/drug use and sexual activities go together for you?
☐Always ☐Often ☐Occasionally ☐Never

Has your alcohol use caused a reduction in your sex drive or produced an inability to function sexually? ☐ YES ☐ NO
If yes, please describe: ____

Which do you consider more difficult to control?
☐Drug use ☐Alcohol use ☐Sexual acting out ☐No difficulties

Are you currently receiving medical treatment for addiction? ☐ YES ☐ NO
If YES, Please Identify the following:

Treatment Facility ________________________________

Program Name ________________________________

Date of Admission ________________________________

Case Worker(s) ________________________________

Are you currently participating in AA/NA meetings? ☐ YES ☐ NO
If YES, Please Identify the following:

Meeting Location ________________________________

Meeting Date/Time ________________________________

Date Began Program ________________________________

V. Relationship History

Who do you feel safe with? Explain ____

____

Who is your support? Explain ____

____

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Have you ever been a victim of verbal abuse? ☐YES ☐NO

Have you ever been a victim of psychological abuse? ☐YES ☐NO

Have you ever been a victim of stalking? ☐YES ☐NO

Have you ever been a victim of physical abuse? ☐YES ☐NO

Have you ever been a victim of sexual abuse? ☐YES ☐NO

Do you have an active restraining order against an individual? ☐YES ☐NO

If YES, Please identify the individual which is restrained from contacting you, and any information you can recall regarding the order itself (distance limits, locations, etc.) ________

____

____

Is there any aspect of your sexual behavior that concerns you? Yes ___ No ___
If yes, please explain: ____

____

Have you ever exchanged sex for money? ☐YES ☐NO

Have you ever exchanged sex for other tangible items (e.g. drugs, clothing, electronics, food, etc.)? ☐YES ☐NO

Have you ever exchanged sex for security or a place to sleep? ☐YES ☐NO

If you engaged in prostitution at what age did you begin? ______________

Number of Years involved: _________________

List the areas where you used to regularly prostitute (e.g. streets, hotels, online):

____

____

____

Did you prostitute in other states? ☐YES ☐NO

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If YES, which states: ____

Have you ever been forced to prostitute yourself by a pimp(s)? ☐YES ☐NO

Have you ever been in a relationship with a pimp? ☐YES ☐NO

If YES, please explain (who, how many, what happened?): ____________________

____

____

Have you ever attempted to leave your pimp? ☐YES ☐NO

How many times did you attempt to leave your pimp before you were successful? ______

List any reasons for you being unable to leave your pimp: ____________________

____

____

Have you experienced any emotional difficulties related to your prostitution? ☐YES ☐NO

If YES, please explain (if desired): ______________________________________

____

____

What coping mechanisms do you use to deal with any emotional difficulties or feelings you have related to your prostitution? ______________________________________

____

____

Have you received an STD test in the last two months? ☐YES ☐NO

Do you currently have an STD? ☐YES ☐NO

If YES, are you being treated for it? ☐YES ☐NO Treatment provider: __________

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If you are accepted into the Residential Program, will you be able to self-administer your treatment/medication? ☐YES ☐NO

V. Mental Health Information

Have you ever experienced any of the following:

Neglect	☐YES ☐NO	Age____
Separation from primary caregiver	☐YES ☐NO	Age____
Family Secrets	☐YES ☐NO	Age____
Emotional abuse	☐YES ☐NO	Age____
Physical abuse	☐YES ☐NO	Age____
Sexual abuse	☐YES ☐NO	Age____
Witness any abuse of others	☐YES ☐NO	Age____
Alcohol/drug abuse by caregivers	☐YES ☐NO	Age____

Have you ever had any of the following symptoms?

Memory lapses	☐YES ☐NO
Spacing Out	☐YES ☐NO
Loosing Track of time	☐YES ☐NO
Headaches/Migraines	☐YES ☐NO
Auditory Hallucinations	☐YES ☐NO
Habitual Lying	☐YES ☐NO
Flashbacks	☐YES ☐NO
Nightmares	☐YES ☐NO
Suicidal ideation	☐YES ☐NO
Homicidal ideation	☐YES ☐NO

Have you ever attempted suicide? ☐YES ☐NO

If YES, please explain: ____

____

____

Do you feel that you would like to injure yourself? ☐YES ☐NO

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If yes, please explain: ____

____

____

Do you feel that you would like to injure others? ☐YES ☐NO

If yes, please explain: ____

____

____

Are you depressed at this time? ☐Yes, a lot ☐Yes, a little ☐No

Do you want to live? ☐YES ☐NO

Have you received a Mental Health Diagnosis? ☐YES ☐NO

If YES, Please identify your diagnos(es): ______________________________

____

____

Are you currently receiving medical treatment for mental health? ☐ YES ☐ NO
If YES, Please Identify the following:

Treatment Facility ______________________________

Program Name ______________________________

Psychiatric Doctor ______________________________

Other health provider ______________________________

Date of Admission ______________________________

Case Worker(s) ______________________________

Are you currently taking medications for your mental health? ☐ YES ☐ NO

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If YES, Please list all medications which have been prescribed, whether you are taking the medications compliantly or not: ____________________

____

____

Have you ever been hospitalized for psychiatric illness or treated for a psychiatric problem? ☐ YES ☐ NO

If YES, please describe: ____________________

____

____

Do you feel you have psychiatric problems at this time? ☐ YES ☐ NO

If YES, please describe: ____________________

____

VI. Physical Health Information

Are you experiencing current medical problems? ☐YES ☐NO

If YES, please describe: ____________________

____

Who is treating you for your medical problems?

Physician Name ____________________

Practice Name ____________________

Practice Location ____________________

Date of Last Visit ____________________

Please list any prescription medications you are currently taking for your physical ailments: ____________________

____

____

Are you experiencing current dental problems? ☐YES ☐NO

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If YES, please describe: ____

____

Who is treating you for your dental problems?

Physician Name ____

Practice Name ____

Practice Location ____

Date of Last Visit ____

Please list any prescription medications you are currently taking for your dental ailments:

____

____

____

Do you feel you need medical treatment at this time? ☐YES ☐NO

If YES, please describe: ____

____

What was the date of your last physical? ______________________________

Are you pregnant? ☐YES ☐NO

Do you wear glasses/contacts? ☐YES ☐NO When was your last eye exam? __________

Do you have any physical disabilities? ☐YES ☐NO

If YES, please describe: ____

____

Do you have any speech problems? ☐YES ☐NO

If YES, please describe: ____

____

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Do you have any hearing problems? ☐YES ☐NO

If YES, please describe: ____

____

Do you have health insurance? ☐YES ☐NO

Have you filed for Social Security or Social Security Disability? ☐YES ☐NO

Please describe the purpose of filing for SSDI: ____

____

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VII. Criminal Justice/Incarceration Information

If you are currently incarcerated please answer the following:

Where are you incarcerated? ____

What is your sentence? ____

When will you be eligible for probation/parole? _____________________________

If you are not currently incarcerated, please answer the following:

Are you currently:

On probation? ☐YES ☐NO

On parole? ☐YES ☐NO

Diversion program? ☐YES ☐NO

If YES, please provide the following details:

Lawyer ____

Lawyer Phone Number ____

Parole/Probation Officer ____

Officer Phone Number ____

Additional requirements ____

____

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Criminal History

Approximate number of arrests: __________ Approximate number of incarcerations: _________

List of most recent charges and sentences:

Charge: _____________________________________ Sentence: __________________________________

Charge: _____________________________________ Sentence: __________________________________

Charge: _____________________________________ Sentence: __________________________________

Charge: _____________________________________ Sentence: __________________________________

Do you have any active warrants? ☐YES ☐NO

If YES, please provide:

Charge: _____________________________________ Court: _____________________________________

Charge: _____________________________________ Court: _____________________________________

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