NEW LIFE
DREAM CENTERS
new life . new hope . new dreams

APPLICATION FOR ENTRY

OFFICE USE ONLY: APPLICANT _____

DATE OF INTERVIEW _____ DATE OF ENTRY _____

DATE OF: ☐ GRADUATION ☐ DISMISSAL ☐ VOLUNTARY EXIT _____

NEW LIFE DREAM CENTERS APPLICATION

Program Entered: ❑ NLDC Men's Program ❑ NLDC Women's Program ❑ NLDC Re-entry

Date entered: _____ Time Entered: _____ ❑ AM ❑ PM Referred by:_____

First Name _____ **Last Name** _____ **MI** _____

Address _____

City _____ **State** _____ **Zip** _____ **Phone** _____

Social Security Number _____ **Date of Birth** _____ **Age:** _____

Gender: ❑ Male ❑ Female **Sexual Orientation:** Heterosexual ❑ Homosexual ❑ Bisexual ❑

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino

Race:

❑ White
❑ Black or African-American
❑ American Indian or Alaskan Native
❑ Asian
❑ Native Hawaiian or Pacific Islander
❑ Other Multi-racial
❑ Don't Know
❑ Refused

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

U.S. Citizen ❑ Yes ❑ No **If NO, do you have a U.S. resident card ("Green Card")?** ❑ Yes ❑ No
Are you a U.S. Veteran: ❑ Yes ❑ No

Housing type prior to entering program:

❑ Non-housing (street, park, car, etc.)
❑ Emergency shelter, including hotel
❑ Transitional housing for homeless persons
❑ Permanent housing for homeless persons
❑ Psychiatric facility
❑ Substance abuse treatment facility
❑ Home owned by client
❑ Home owned by client w/ subsidy
❑ Rental by client
❑ Rental by client w/ VASH subsidy
❑ Rental by client, w/ subsidy
❑ Safe Haven
❑ Staying with family
❑ Staying with friends
❑ Foster care
❑ Hospital (non-psychiatric)
❑ Jail/Prison

Last Zip Code: _____

Do you have a Disabling Condition? ❑ Yes ❑ No **Do you have or had any of the following?**

❑ Alcohol Abuse ❑ Treatment or services received: _____
❑ Drug Abuse ❑ Treatment or services received: _____
❑ HIV/AIDS ❑ Treatment or services received: _____
❑ Developmental Disability ❑ Treatment or services received: _____
❑ Chronic Health Condition ❑ Treatment or services received: _____
❑ Physical Disability ❑ Treatment or services received: _____
❑ Mental Health Issues ❑ Treatment or services received: _____

Are you a Victim of Domestic Violence? ❑ Yes ❑ No If so, when was your last occurrence? _____

Drug and Alcohol History

Substance	Frequency	Amount	Age of First Use	Date Last Used

Medical

Current Medical Issues _____

Currently receiving treatment _____

Clinic/Hospital/Doctor Providing treatment _____

Inpatient/Outpatient _____

List any medications _____

Comments _____

Mental Health

Currently receiving services _____ Problem Date _____ Diagnosis _____

Treatment Location _____ Medication _____ Meds last Date taken: _____

Arrest History

Charge Type: ❑ Felony ❑ Misdemeanor ❑ Other ❑ None

Charge: _____ Arrest Date _____ Convicted? ❑ Yes ❑ No ❑ N/R

Conviction Date _____ City / State / County _____

Comments: _____

Have you ever been convicted of a felony? ❑Yes ❑No If Yes, what was the nature of the crime? _____

_____

Have you ever been convicted of a sex crime? ❑ Yes ❑No

Are you registered, or do you need to register as a sex offender? ❑ Yes ❑No

Are you currently on Probation? ❑ Yes ❑ No **Are you currently on Parole?** ❑ Yes ❑ No

❑ City _____ ❑ County _____ ❑ State_____

Officer:_____ Terms:_____

Phone:_____ Date Last contacted:_____

Comments:_____

Do you have any outstanding Warrants? ❑ Yes ❑ No

Charge Type: ❑ Felony ❑ Misdemeanor ❑ Other ❑ None

Charge:_____ City / State / County_____

Income

Employment at Entry: ❑Full ❑Part ❑Disability ❑Unemployed

Most Recent Employer: _____ **Start Date:** _____ **End Date:** _____

Employer Address: _____ **Phone:** _____

Reason for Leaving: ❑**Fired/Laid Off** ❑**Quit** **Job Title, Duties & Skills Used:** _____

Do you have any income sources? ❑ **Yes** ❑ **No** **(If Yes, select income and list monthly income below)**

❑ Employment income	$ _____	❑ Workers' Comp	$ _____	❑ Job pension	$ _____
❑ Unemployment	$ _____	❑ TANF	$ _____	❑ Child support	$ _____
❑ Social Security Income	$ _____	❑ General assistance	$ _____	❑ Alimony	$ _____
❑ Social Security Disability	$ _____	❑ SSA retirement	$ _____	❑ Other source	$ _____
❑ Veterans disability	$ _____	❑ Veteran's pension	$ _____	❑ Disability	$ _____
❑ Private disability insurance	$ _____	❑ Food stamps	$ _____	❑ No financial resource	

Are you receiving any Non-Cash Benefits? ❑ **Yes** ❑ **No** **(If Yes, please check boxes below that apply.)**

❑ Food Stamps	❑ WIC Supplemental Nutrition Program	❑ Other TANF funded services
❑ Medicaid	❑ VA Medical Services	❑ Section 8 Public Housing
❑ Medicare	❑ TANF Childcare Services	❑ Temporary Rental Assistance
❑ State Children's Health Insurance	❑ TANF Transportation Services	❑ Other source _____

❑ Private Health Insurance: Name of Provider _____ Group / Policy #_____

Education Level

Currently in School ❑ Yes ❑ No

Current Occupational Skills _____

Machine Skills _____

Computer Skills _____

Vocational Training _____

Highest Level of Education _____

Comments _____

_____

Marriage Information

Spouse Name _____

Address _____ **City** _____

State _____ **Zip** _____ **Phone** _____ **E-Mail** _____

Name of Child	Age	Social Security #

Are you ordered by the court to make child support payments? ❑ **Yes** ❑ **No**

If Yes, how much per week?_____ **Where is it Sent?**_____

Do you owe back-payments for child support? ❑ **Yes** ❑ **No If Yes, how much do you owe?**_____

Family Members

First Name _____ **Last Name** _____ **MI** _____

Address _____ **City** _____

State _____ **Zip** _____ **Phone** _____ **E-Mail** _____

Age _____ **Marital Status** _____ **Relationship** _____

First Name _____ **Last Name** _____ **MI** _____

Address _____ **City** _____

State _____ **Zip** _____ **Phone** _____ **E-Mail** _____

Age _____ **Marital Status** _____ **Relationship** _____

Emergency Contacts

First Name _____ **Last Name** _____ **MI** _____

Address _____ **City** _____

State _____ **Zip** _____ **Phone** _____ **E-Mail** _____

First Name _____ **Last Name** _____ **MI** _____

Address _____ **City** _____

State _____ **Zip** _____ **Phone** _____ **E-Mail** _____

Visitation and Phone Requests

Please list family members and friends whom you would like to place calls to, or receive calls and visits from while you are in the New Life Dream Center. Please include phone numbers and relationship to you. **Please note: You will not be able to get visits or calls from, or place calls to, anyone not on this list, nor will you be allowed to call phone numbers not listed here. These contacts are also subject to NLDC approval.**

Name:__________________________________ **Relationship to You:**______________________________________

Phone Numbers:(____)___________________ **(____)**___________________ **E-mail**_______________________

Name:__________________________________ **Relationship to You:**______________________________________

Phone Numbers:(____)___________________ **(____)**___________________ **E-mail**_______________________

Name:__________________________________ **Relationship to You:**______________________________________

Phone Numbers:(____)___________________ **(____)**___________________ **E-mail**_______________________

Name:__________________________________ **Relationship to You:**______________________________________

Phone Numbers:(____)___________________ **(____)**___________________ **E-mail**_______________________

Name:__________________________________ **Relationship to You:**______________________________________

Phone Numbers:(____)___________________ **(____)**___________________ **E-mail**_______________________

Name:__________________________________ **Relationship to You:**______________________________________

Phone Numbers:(____)___________________ **(____)**___________________ **E-mail**______________________

Name:__________________________________ **Relationship to You:**______________________________________

Phone Numbers:(____)___________________ **(____)**___________________ **E-mail**_______________________

Name:__________________________________ **Relationship to You:**______________________________________

Phone Numbers:(____)___________________ **(____)**___________________ **E-mail**_______________________

Name:__________________________________ **Relationship to You:**______________________________________

Phone Numbers:(____)___________________ **(____)**___________________ **E-mail**_______________________

Name:__________________________________ **Relationship to You:**______________________________________

Phone Numbers:(____)___________________ **(____)**___________________ **E-mail**_______________________

NEW LIFE DREAM CENTERS
PERSONAL QUESTIONNAIRE

1. Do you know that this is a 12-month program and that you must commit yourself to the full 12 months? ❑ Yes ❑ No

2. Do you understand that this is a Christian program operated on biblical principles? ❑ Yes ❑ No

3. What is your religious background? _____
   Have you ever accepted Jesus Christ as your Lord and Savior? ❑ Yes ❑ No

4. Are you willing to live life under the authority of Jesus Christ as your Lord? ❑ Yes ❑ No
   Do you know what it means to live under God's authority? ❑ Yes ❑ No

5. Explain why you want to enter this program.
   _____
   _____
   _____

6. What area(s) of your life do you want to change? Please explain:
   _____
   _____
   _____

7. How do you feel this program can help you accomplish these changes?
   _____
   _____
   _____

8. What are you hoping to learn while you are here?
   _____
   _____
   _____

9. Do you have any hobbies or talents?
   _____
   _____
   _____

10. Have you read the Rule Book carefully? ❑ Yes ❑ No
    Do you agree with the rules of the program? ❑ Yes ❑ No
    There will be no compromising the rules once you are in the program.

11. Do you realize that every rule in the Rule Book must be kept? If not, you will receive special blessings or possible suspension from the program. ❑ Yes ❑ No

12. Do you have any physical disablilities that would limit your ability to complete general tasks such as sweeping, mopping, cleaning, etc.? ❑ Yes ❑ No

If you have a physical disability, please note it here:

_____

13. Do you understand that smoking is not permitted in the program? ☐ Yes ☐ No

14. Do you know what it means to live in a controlled environment? ☐ Yes ☐ No

15. Do you have any court cases pending? (In case you forgot to list them before, now is the time to tell us.) ☐ Yes ☐ No If yes, please explain:

    _____

    _____

    _____

16. Have you ever been convicted of a sex crime? ☐ Yes ☐No

17. Are you on parole or probation? (In case you forgot to tell us before, now is the time to do so.) ☐ Yes ☐No

18. Which of the following forms of identification do you have? Check all that apply.
    ☐ Driver's License ☐ Picture I.D. ☐ Original Birth Certificate. ☐ Social Security Card.

    ☐ V.A. papers ☐ Green Card ☐ Other:_____

19. Do you realize that there is an **application fee of $75 and a monthly room and board fee of $750?**
    ☐ Yes ☐ No **Method of payment:** ☐ Credit Card ☐ Cash ☐ Check

20. I agree to a complete and thorough search of my self, including my belongings, upon entry into the New Life Dream Centers for Men and Women. My Initials_____

Applicant Signature: _____ Date: _____

Interviewer's Signature: _____ Date: _____

Interviewer's Signature: _____ Date: _____

NEW LIFE DREAM CENTER
COMMITMENT

1. Are you sincerely ready to turn back on your old way of life and accept Jesus Christ as your Lord? ☐ Yes ☐ No

2. Are you willing to submit to all authority placed over you, as well as to all the rules and regulations that govern this Program? (See Rule Book) ☐ Yes ☐ No

3. Do you understand that by breaking one or any of the above rules (See Rule Book) you can be dismissed from the New Life Dream Center? ☐ Yes ☐ No

I hereby declare that all of the information given in this application is true. I further grant permission to the New Life Dream Center to check all information and interview all parties listed on this application. I further understand that any false information can result in immediate dismissal.

Applicant Signature: _____ Date: _____

Interviewer's Signature: _____ Date: _____

Director's Signature: _____ Date: _____

Office Use Only

Date accepted_____ Date Rejected_____

Pastor:_____ Date:_____

Program Director:_____ Date:_____

NEW LIFE **DREAM CENTERS**

FINANCIAL AGREEMENT

I,_____ , understand that there is a $750 monthly Program fee for each of the 12 months that I participate in the Program. My signature verifies that any funds I receive from the Department of Social Security, other government sources, gifts and sponsors, or personal savings will be applied to the breakdown 10, 50, 40. If I have no source of income, other financial support alternatives will be discussed. I further understand that in case I do not complete the program (as a result of voluntary dismissal or suspension) any funds held in my account will be used to satisfy all applicable fees. Authorizing credit charges will be suspended. No pro-rated refund will be issued.

Financial breakdown of all monies:

10% "Tithe"

50% "Open Account" Monthly $750 Program fees and one time application fee of $75.

40% "Savings Account" *Up to $1000 anything above that amount will be applied to the Program fees until paid in full.

* Cannot be accessed until student has completed program.

Disclaimer: If a student comes into NLDC with any form of income (i.e. SSI or SSDI) we will allot a portion toward their Program Fee and their savings account on a case by case basis. This will be discussed with Student upon acceptance into the Program. If the student has finances, they will speak with the Finance Department about their monetary obligations.

I, _____ , understand that gift cards are not allowed into the New Life Dream Centers 12-month Program.

Exception only: Program fees paid in full along with authorization from New Life Dream Center Director of Operations.

PAYMENT METHOD

Cash ❑ Check ❑ Credit Card ❑ PayPal ❑ SSI/SSDI ❑ Other ❑

I, _____ , authorize New Life Dream Centers Business Office the use of my SSI/SSDI credit card/Direct Express card to satisfy all fees incurred.

Applicant's Signature:_____ Date:_____

NOTE: If a student leaves prior to completing the program all monies in the Savings account will be credited to outstanding balance of Program Fees until paid in full. Remaining balance will go to resident.

FOOD STAMP AUTHORIZATION FORM

I _____ hereby declare that the New Life Center is authorized to apply and oversee all registration Proceedings for my Food Stamp Solicitation and EBT Card, through The Florida Department of Children and Families. I certify that I have the authority to execute this authorization form, bearing in mind that all information given to the New Life Center is not fraudulent or false. I understand that to willfully provide or present a document that is fraudulent or false is a criminal offence.

Print or Type

Food Stamp Solicitor Information *name(s) and address:*	***Enter only those that apply***
	DATE OF BIRTH.
	SOCIAL SECURITY NO.
	NEW APPLICANT ☐ OPEN CASE ☐
	CASE /CARD #. _____

Name of Authorized Representative Information :

Signature: _____ Date: _____
(*Food Stamp Solicitor)*

Signature: _____ Date: _____
(New Life Director)

New Life Director: _____

Signature: _____ Date: _____
(Authorized Representative)

I, _____, acknowledge and understand that while I am a student in the New Life Dream Center, my Food Stamps card will be held and used by NLDC Staff Personnel only. NLDC Staff Personnel will use my card to purchase my food for me. I also understand that upon my departure from NLDC, my Food Stamps card will be returned to me during Office hours only, and or destroyed. Upon my departure, I will be required to re-apply for my benefits outside NLDC.

Applicant signature: _____ Date: _____

Interviewer signature: _____ Date: _____

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

Resident Name _____ Date of birth _____

Authorization for __X___ Request for information ___X__ Release of information

I authorize the NEW LIFE DREAM CENTER BUSINESS OFFICE to request/release information and/or records of the individual named above.

I understand that my clinical record may include information relating to HIV/AIDS, behavioral or mental health services and/or substance abuse services.

The information and request are for the purpose of benefits and counseling.

Information to be released includes:
____X____ All information
____X____ Specific information/reports, such as **Benefits and Counseling**

I understand that I have a right to cancel this authorization at any time by presenting my written cancellation to the NLDC Records Department. I understand that the above information may be disclosed by the recipient of the information that has already been released in response to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I do not cancel his authorization it automatically expires a follows.

PLEASE INITIAL ONE CHOICE:

_____ Six month after the date on which my treatment is completed
_____ On _____/_____/_____
____X____ One time only for current records/information

I understand that authorizing the disclosure of this information is voluntary. I do not need to sign this form in order receive services. I understand that the above information may be disclosed by the recipient of the information. Most health care providers and insurance plans must follow federal rules protecting the privacy of the health information. However, NEW LIFE DREAM CENTERS cannot guarantee that others receiving information will protect it.

_____ _____
Client or Legal Representative Signature Date

_____
If signed by Legal Representative, Describe relationship to Client

_____
Witness Signature

Verification of Homeless Status Form

"I _____ hereby verify that I am presently in a homeless situation. I do not own a home, nor do I have my name on a mortgage or lease. Should my name be on any such document, I am required to provide foreclosure/eviction documentation prior to entering the NLDC. I hereby swear that I am without permanent or stable residence or at risk of becoming homeless. In addition, there may be other issues, which may have contributed to my homeless situation, and I have reviewed these issues with New Life Dream Center.

(Please describe your homeless situation in your own words)

_____

_____

_____

_____

_____

I understand that I may be ineligible from any funding provided by the Housing and Urban Development should any statements or documents of homelessness/eviction are fraudulent." With this signed affidavit, I will attempt to provide any form of documentation to substantiate claims of foreclosure or eviction.

(This Homeless Verification has been reviewed by NLDC staff with the following observations)

_____

_____

_____

_____

_____ _____ _____

Applicant Signature Print Name Date

_____ _____ _____

Applicant Signature Print Name Date

(Applicable only when applicant's signature is marked with an "X")

_____ _____ _____

Staff Signature Print Name Date

_____

Applicant Date of Birth

Forget the former things;
do not dwell on the past.
See, I am doing a new thing…
Now it springs up…
I am making a way in the desert
and streams in the wasteland.
— Isaiah 43:18, 19

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More than 35 years of changed lives