



## NEW LIFE FOR YOUTH ENROLLMENT APPLICATION

GENERAL INFORMATION					
FIRST NAME		LAST NAME		MIDDLE	
CURRENT ADDRESS			CITY		STATE
EMAIL ADDRESS			PHONE		DATE OF BIRTH
GENDER (Circle) M    F					
ARE YOU A U.S. CITIZEN? Y    N	IF YES, WHAT STATE IS YOUR RESIDENCE?		IF NO, WHAT IS YOUR COUNTRY OF RESIDENCE?		
<b>MARITAL STATUS</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> ENGAGED <input type="checkbox"/> SEPERATED <input type="checkbox"/> DIVORCED			<b>RACE</b> <input type="checkbox"/> AFRICAN-AMERICAN <input type="checkbox"/> CAUCASION <input type="checkbox"/> HISPANIC <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER <input type="checkbox"/> MULTI-CULTRUAL		
DO YOU READ AT A 5 <sup>TH</sup> GRADE LEVEL?		DO YOU HAVE A HIGH SCHOOL DIPLOMA?		DO YOU HAVE A GED?	
DO YOU HAVE FRIENDS OR RELATIVES IN THIS PROGRAM?			HAVE YOU BEEN ENROLLED AT NEW LIFE FOR YOUTH BEFORE?		
WHAT DO YOU PRIMARILY NEED HELP WITH? ALCOHOL    DRUGS    OTHER ( <i>Explain</i> ):				DO YOU USE TOBACCO? Y    N	
HAVE YOU EVER BEEN TREATED AT AN ADDICTION RECOVERY FACILITY?    Y    N    ( <i>If yes, provide facility information below</i> )					
FACILITY 1	FACILITY NAME		ADDRESS		
	CITY		STATE		ZIP
	TREATMENT DATE RANGE		REASON FOR TREATMENT		DID YOU COMPLETE TREATMENT? Y    N
FACILITY 2	FACILITY NAME		ADDRESS		
	CITY		STATE		ZIP
	TREATMENT DATE RANGE		REASON FOR TREATMENT		DID YOU COMPLETE TREATMENT? Y    N
HOW DID YOU HEAR ABOUT NEW LIFE FOR YOUTH?					

**GENERAL INFORMATION (CONTINUED)**

**IN YOUR OWN WORDS, TELL US WHY YOU WANT TO COME TO NEW LIFE FOR YOUTH AND THE MAIN ISSUES YOU NEED TO DEAL WITH WHILE IN THE PROGRAM.**

**PHYSICAL HEALTH**

**MEDICAL HISTORY** *(Check all that apply to your current and past conditions).*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ALCOHOL ABUSE        | <input type="checkbox"/> ASTHMA          | <input type="checkbox"/> BACK PROBLEMS |
| <input type="checkbox"/> BROKEN BONES/SPRAINS | <input type="checkbox"/> DIABETES        | <input type="checkbox"/> DRUG ABUSE    |
| <input type="checkbox"/> HEAD TRAUMA/TBI      | <input type="checkbox"/> HEART CONDITION | <input type="checkbox"/> HEPATITIS     |
| <input type="checkbox"/> HIGH BLOOD PRESSURE  | <input type="checkbox"/> HIV/AIDS        | <input type="checkbox"/> MIGRAINES     |
| <input type="checkbox"/> RESPIRATORY PROBLEMS | <input type="checkbox"/> SEIZURES        | <input type="checkbox"/> STI/STD       |
| <input type="checkbox"/> TUBERCULOSIS         |  |  |

**PLEASE LIST ANY CURRENT MEDICAL CONCERNS YOU MAY HAVE:**

**ARE YOU CURRENTLY BEING TREATED BY A DOCTOR?** Y N *(If yes, provide contact information below)*

<b>PRIMARY DOCTOR INFORMATION</b>	<b>NAME</b>	<b>ADDRESS</b>	
	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
	<b>OFFICE PHONE</b>	<b>FAX</b>	
	<b>DATES OF TREATMENT</b> FROM:      /      /                      TO:      /      /		
	<b>REASON FOR TREATMENT</b>		

**ARE YOU PREGNANT?** Y N  
If yes, what is your due date?      /      /

PHYSICAL HEALTH (CONTINUED)			
ARE YOU ALLERGIC TO ANY MEDICATIONS?    Y    N    If yes, please list them below:			
ARE YOU CURRENTLY BEING TREATED WITH PRESCRIBED NARCOTIS?    Y    N    If yes, please list them below:			
ARE YOU CURRENTLY PRESCRIBED ANY NON-PSYCHIATRIC MEDICATIONS?    Y    N If yes, please list the medication, reason, and dosage below:			
MEDICATIONS	MEDICATION	REASON	DOSAGE
	MEDICATION	REASON	DOSAGE

SPECIAL NEEDS			
DO YOU HAVE ANY TYPE OF DISABILITY?    Y    N    If yes, please explain.			
DO YOU HAVE ANY CHRONIC CONDITIONS?    Y    N    If yes, please explain.			
DO YOU HAVE ANY MEDICAL RESTRICTIONS?    Y    N    If yes, please explain.			
DO YOU HAVE ANY TYPE OF SPECIAL NEEDS?    Y    N    If yes, please explain.			
DO YOU HAVE ANY ALLERGIES?    Y    N    If yes, please explain.			
DO YOU REQUIRE A SPECIAL DIET?    Y    N    If yes, please explain.			

DENTAL & VISION HEALTH			
DO YOU HAVE ANY DENTAL ISSUES THAT NEED TREATMENT?    Y    N    If yes, please explain.			
DO YOU WEAR GLASSES OR CONTACTS?    Y    N		DO YOU HAVE YOUR GLASSES OR REPLACEMENT CONTACTCS?    Y    N	

MENTAL HEALTH			
<b>HAVE YOU EVER BEEN TREATED FOR MENTAL DISORDERS?</b> Y    N <div style="text-align: right;">If yes, when?    /    /</div>			
<b>HAVE YOU EVER BEEN TREATED BY A PSYCHIATRIST/PSYCHOLOGIST?</b> Y    N    If yes, please provide the following information:			
<b>PSYCHIATRIST/PSYCHOLOGIST</b>	<b>NAME</b>		<b>ADDRESS</b>
	<b>CITY</b>		<b>STATE</b> <b>ZIP</b>
	<b>OFFICE PHONE</b>		<b>FAX</b>
	<b>DATES OF TREATMENT</b> FROM:    /    /    TO:    /    /		
	<b>REASON FOR TREATMENT</b>		
<b>ARE YOU CURRENTLY PRESCRIBED ANY PSYCHIATRIC MEDICATIONS?</b> Y    N If yes, please list the medication, reason, and dosage below:			
<b>MEDICATIONS</b>	<b>MEDICATION</b>	<b>REASON</b>	<b>DOSAGE</b>
	<b>MEDICATION</b>	<b>REASON</b>	<b>DOSAGE</b>
<b>PLEASE, TELL US OF ANY CURRENT MENTAL/EMOTIONAL HEALTH CONCERNS YOU MAY HAVE:</b>  			
<b>HAVE YOU THOUGHT ABOUT OR ATTEMPTED SUICIDE IN THE PAST SIX MONTHS?</b> Y    N <div style="text-align: right;">If yes, when?    /    /</div>			
<b>MENTAL HEALTH HISTORY</b> <i>(Check all that apply to your current and past conditions).</i>			
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ANOREXIA	<input type="checkbox"/> ANXIETY DISORDER	
<input type="checkbox"/> BIPOLAR DISORDER	<input type="checkbox"/> BULIMIA	<input type="checkbox"/> DEPRESSION	
<input type="checkbox"/> HALLUCINATIONS	<input type="checkbox"/> HEARING VOICES	<input type="checkbox"/> HOMICIDAL THOUGHTS/TENDENCIES	
<input type="checkbox"/> INSOMNIA	<input type="checkbox"/> MULTIPLE PERSONALITIES	<input type="checkbox"/> PARANOIA	
<input type="checkbox"/> PERSONALITY DISORDER	<input type="checkbox"/> PHYSICAL ABUSE	<input type="checkbox"/> POST TRAUMATIC STRESS DISORDER	
<input type="checkbox"/> RAPE VICTIM	<input type="checkbox"/> SEXUAL ABUSE	<input type="checkbox"/> SCHIZOAFFECTIVE DISORDER	
<input type="checkbox"/> SCHIZOPHRENIA	<input type="checkbox"/> SUICIDAL ATTEMPT	<input type="checkbox"/> SUICIDAL THOUGHTS	

<b>LEGAL ISSUES</b>			
<b>ARE YOU CURRENTLY ON PROBATION?</b> Y    N    If yes, please provide the following information:			
<b>PROBATION CONTACT INFORMATION</b>	STATE AND COUNTY OF PROBATION		
	PROBATION OFFICER'S NAME	PROBATION OFFICER'S ADDRESS	
	CITY	STATE	ZIP
	PROBATION OFFICER'S OFFICE PHONE	PROBATION OFFICER'S CELL PHONE	
	FAX	PROBATION OFFICER'S EMAIL ADDRESS	
<b>ARE YOU CURRENTLY ON PAROLE?</b> Y    N    If yes, list the state and county of your parole.			
<b>DO YOU CURRENTLY HAVE ANY COURT CASES PENDING?</b> Y    N    If yes, please provide the following information:  State and county of your hearing(s):  Court dates and nature of charge(s):			
<b>ARE YOU CURRENTLY UNDER INVESTIGATION?</b> Y    N    If yes, list the state and county conducting the investigation.			
<b>DO YOU HAVE ANY OUTSTANDING WARRANTS FOR YOUR ARREST?</b> Y    N    If yes, list the state and county of the warrant(s)			
<b>HAVE YOU EVER BEEN CONVICTED OF A VIOLENT CRIME?</b> Y    N    If yes, list each conviction and date.			
<b>ARE YOU CURRENTLY FACING CHARGES FOR A VIOLENT OR SEX-RELATED CRIME?</b> Y    N    If yes, describe the charges.			
<b>ARE YOU REQUIRED TO REGISTER AS A SEXUAL OR PREDATORY OFFENDER?</b> Y    N			
<b>DO YOU HAVE AN ATTORNEY?</b> Y    N    If yes, please provide the following information:			
<b>ATTORNEY INFORMATION</b>	ATTORNEY'S NAME	ADDRESS	
	CITY	STATE	ZIP
	OFFICE PHONE	CELL PHONE	
	FAX	ATTORNEY'S EMAIL ADDRESS	

### LEGAL ISSUES (CONTINUED)

**LEGAL HISTORY** (Check all that you have been involved with)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDING & ABETTING       | <input type="checkbox"/> ATTEMPTED MURDER  | <input type="checkbox"/> ATTEMPTED ROBBERY     |
| <input type="checkbox"/> BATTER                  | <input type="checkbox"/> CREDIT CARD FRAUD | <input type="checkbox"/> DRUG DISTRIBUTION     |
| <input type="checkbox"/> DUI                     | <input type="checkbox"/> DWI               | <input type="checkbox"/> EMBEZZLEMENT          |
| <input type="checkbox"/> FRAUD                   | <input type="checkbox"/> IDENTITY THEFT    | <input type="checkbox"/> LARCENY/GRAND LARCENY |
| <input type="checkbox"/> MANSLAUGHTER            | <input type="checkbox"/> MURDER            | <input type="checkbox"/> PAROLE VIOLATION      |
| <input type="checkbox"/> PROSTITUTION            | <input type="checkbox"/> SEX WITH A MINOR  | <input type="checkbox"/> SHOPLIFTING           |
| <input type="checkbox"/> SOLICITING PROSTITUTION | <input type="checkbox"/> OTHER             |  |

If other, please list:

### EMERGENCY CONTACT

<b>EMERGENCY CONTACT NAME</b>		<b>EMERGENCY CONTACT RELATION</b>	
<b>ADDRESS</b>		<b>CITY</b>	
<b>STATE</b>	<b>ZIP</b>	<b>EMAIL ADDRESS</b>	
<b>HOME PHONE</b>	<b>CELL PHONE</b>		<b>WORK PHONE</b>

### FINANCIAL INFORMATION

<b>ARE YOU CURRENTLY EMPLOYED?</b>	Y    N	If yes, what is your monthly income?
<b>DO YOU RECEIVE ANY OTHER INCOME (SSI, Disability, etc.)?</b>	Y    N	If yes, what is the monthly amount?
<b>DO YOU CURRENTLY RECEIVE GOVERNMENT ASSISTANCE?</b>	Y    N	If yes, what type?

**PROGRAM FEE INFORMATION**

New Life For Youth incurs a cost of \$1,600 per month for each student in residence. All applicants are responsible for seeking monthly sponsorship for costs beyond what they can afford. Additionally, an Induction Fee of \$750 and a Case Management Fee of \$500 is due at the time of admission. Partial scholarships may be available based on financial need. To be considered for need-based scholarship, please complete the following information as accurately as possible.

**HOW MUCH OF THE MONTHLY PROGRAM COST (\$1,600.00) CAN YOU AFFORD TO PAY?**

\$ \_\_\_\_\_ PER MONTH FOR 12 MONTHS

**CHECK ANY/ALL OF THE FOLLOWING PERSONAL ASSETS AND INCOME YOU HAVE AND LIST THE VALUE OF EACH**

<input type="checkbox"/> VEHICLES	VALUE \$ _____	<input type="checkbox"/> CHECKING ACCOUNT	VALUE \$ _____
<input type="checkbox"/> PROPERTY	VALUE \$ _____	<input type="checkbox"/> SAVINGS ACCOUNT	VALUE \$ _____
<input type="checkbox"/> 401K	VALUE \$ _____	<input type="checkbox"/> SETTLEMENT PAYMENTS	VALUE \$ _____
<input type="checkbox"/> CHILD SUPPORT	VALUE \$ _____	<input type="checkbox"/> TRUST FUND	VALUE \$ _____
<input type="checkbox"/> ALIMONY	VALUE \$ _____	<input type="checkbox"/> OTHER	VALUE \$ _____
<input type="checkbox"/> SSI DISABILITY	VALUE \$ _____		

**CERTIFICATION AND AGREEMENT**

By my signature below, I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that, should an investigation disclose untruthful or misleading answers, I may be discharged from the New Life For Youth program. Furthermore, I understand that New Life For Youth is a Christian, faith-based program.

Please initial the following lines to indicate that you have received, read, and agree to abide by the program guidelines listed below.

\_\_\_\_\_ Program Policies and General Information

\_\_\_\_\_ Room and Board Fee Information

\_\_\_\_\_ Prohibited Medication

\_\_\_\_\_ Applicant Signature \_\_\_\_\_ Date

**Please, mail or fax completed applications to:**

Men: 1500 Log Cabin Road  
 Beaverdam, VA 23015  
 Phone: (804) 448-2750  
 Fax: (804) 448-4071

Women: 2320 Broad Rock Blvd.  
 Richmond, VA 23224  
 Phone: (804) 230-4485  
 Fax: (804) 230-6320