



OASIS HOUSE

Resident Application

425 N. Findlay St.
Dayton, Oh 45404
937-898-7811
937-461-3630(fax)

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 a **two-year** program, with possible extensions or exceptions that can be made based on the resident's individual needs. 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 from 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
- 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

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: _____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 NO

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 _____

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

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: _____

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 | <input type="checkbox"/> YES <input type="checkbox"/> NO | Age_____ |
| Separation from primary caregiver | <input type="checkbox"/> YES <input type="checkbox"/> NO | Age_____ |
| Family Secrets | <input type="checkbox"/> YES <input type="checkbox"/> NO | Age_____ |
| Emotional abuse | <input type="checkbox"/> YES <input type="checkbox"/> NO | Age_____ |
| Physical abuse | <input type="checkbox"/> YES <input type="checkbox"/> NO | Age_____ |
| Sexual abuse | <input type="checkbox"/> YES <input type="checkbox"/> NO | Age_____ |
| Witness any abuse of others | <input type="checkbox"/> YES <input type="checkbox"/> NO | Age_____ |
| Alcohol/drug abuse by caregivers | <input type="checkbox"/> YES <input type="checkbox"/> NO | Age_____ |

Have you ever had any of the following symptoms?

- | | |
|-------------------------|--|
| Memory lapses | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Spacing Out | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Loosing Track of time | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Headaches/Migraines | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Auditory Hallucinations | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Habitual Lying | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Flashbacks | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Nightmares | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Suicidal ideation | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Homicidal ideation | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Have you ever attempted suicide? YES NO

If YES, please explain: _____

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

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

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

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: _____

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: _____

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 _____

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: _____