



Lansing Teen Challenge Student Application

(*Please note that there is a \$500.00 induction fee)

Student's Name: _____ SSN: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: () _____ - _____ Sex: Male Female

Date of Birth: ____/____/____ Height: _____ Weight: _____ Age: _____

State of Legal Residency: _____ County: _____

Driver License Number: _____ State: _____

Race:

____ White
 ____ Black
 ____ Hispanic
 ____ American Indian
 ____ Asian
 ____ Other: _____

Marital Status:

____ Single
 ____ Married
 ____ Divorced
 ____ Separated
 ____ Widowed

I currently live with:

____ Spouse
 ____ Fiancé/Girlfriend
 ____ Parents
 ____ Other family member
 ____ Lock up facility
 ____ Other: _____

Education: (Highest Level Completed)

____ College Degree
 ____ Some College
 ____ Trade School
 ____ High School Diploma
 ____ GED
 ____ Other: _____

I am able to:

____ Read English
 ____ Write English
 ____ Speak English
 ____ Comprehend English

Citizenship

____ United States
 ____ Other: _____

I now have, or have previously had problems with the following: (check all that apply)

____ Gambling ____ Drug Addiction ____ Pornography
 ____ Alcohol Addiction ____ Lying ____ Running Away
 ____ Stealing ____ Violence ____ Other: _____

Military Service:

Branch: _____ Years of service: _____ Date of Discharge: ____/____/____

In case of emergency notify: _____

Relationship: _____ Address: _____

City: _____ State: ____ Zip: _____ Phone: () _____ - _____

Medical Information

Medical History (Check all that apply to your current or past condition)

- | | | |
|---|---|--|
| <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Nervous Condition | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hearing Voices | <input type="checkbox"/> Hepatitis (Type: _____) |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Suicide Attempts | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Homicidal Thoughts | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Homicidal Tendencies | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Paranoia | <input type="checkbox"/> ADD | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> ADHD | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Multiple Personalities | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Rape | <input type="checkbox"/> Disability (describe): _____ | |

List all current medications you take:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List all medications taken in the past 5 years:

1. _____
2. _____
3. _____
4. _____
5. _____

List all Past and Present Dental Problems:

1. _____
2. _____
3. _____
4. _____
5. _____

Substance Abuse: (Check all that you have used)

- | |
|---|
| <input type="checkbox"/> Heroin |
| <input type="checkbox"/> Cocaine |
| <input type="checkbox"/> Crack |
| <input type="checkbox"/> Crank |
| <input type="checkbox"/> LSD |
| <input type="checkbox"/> Methadone |
| <input type="checkbox"/> Amphetamines (Uppers) |
| <input type="checkbox"/> Barbiturates (Downers) |
| <input type="checkbox"/> Marijuana (THC) |
| <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Chewing Tobacco |
| <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Huffing/Sniffing |
| <input type="checkbox"/> Mushrooms |
| <input type="checkbox"/> Hallucinogens |
| <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____ |

Emotional Treatment:

- | | | |
|---|------------------------------|-----------------------------|
| Have you ever been treated by a psychologist? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been treated by a psychiatrist? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been treated for chemical dependency? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been treated for mental disorders? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been treated for sleep disorders? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been treated for an eating disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Medical Information

(Continued)

Prior Treatment Facilities: (Provide information on **all** treatment facilities you have been in during the **past 5 years**)

Facility Name: _____

City: _____ State: _____

Phone: () _____ - _____

Dates: _____ to _____
 Month/Year Month/Year

Completed Program? Yes No

Facility Name: _____

City: _____ State: _____

Phone: () _____ - _____

Dates: _____ to _____
 Month/Year Month/Year

Completed Program? Yes No

Facility Name: _____

City: _____ State: _____

Phone: () _____ - _____

Dates: _____ to _____
 Month/Year Month/Year

Completed Program? Yes No

Facility Name: _____

City: _____ State: _____

Phone: () _____ - _____

Dates: _____ to _____
 Month/Year Month/Year

Completed Program? Yes No

Special Physical Needs: (Check all that apply)

I have a disability: Yes No Type: _____

I need a special diet: Yes No Type: _____

I have medical restrictions: Yes No Type: _____

Other special needs: _____

Doctor Information:

Name: _____

City: _____ State: _____

Phone () _____ - _____

Fax () _____ - _____

General Health:

Excellent

Good

Average

Poor

Very Poor

Do you currently have health insurance: Yes No

If yes: Name of Company: _____

Policy #: _____ Group #: _____

Phone #: () _____ - _____

Will you have insurance while in the program: Yes No

If yes: Name of Company: _____

Policy #: _____ Group #: _____

Phone #: () _____ - _____

Legal Information

Current Legal Status

Do you have any court case pending? Yes No
Do you have to register as a sexual offender? Yes No
Are you required to pay child support? Yes No
If so are you behind in your support payments? Yes No
Are you currently on probation? Yes No
Are you currently on parole? Yes No
Are you required to pay any restitution? Yes No
Do you have any unpaid fines or court costs? Yes No
Do you need court approval to enter this program? Yes No
Are there any outstanding warrants for your arrest? Yes No

Past Legal Status:

Have you ever been arrested? Yes No
If yes, how many times: _____
Have you ever been in a juvenile detention center? Yes No
Have you ever been in jail? Yes No
Have you ever been in prison? Yes No
Have you ever been on probation? Yes No

Legal History: (Check all that you have ever been involved with)

<input type="checkbox"/> Murder	<input type="checkbox"/> Battery	<input type="checkbox"/> Prostitution
<input type="checkbox"/> Attempted murder	<input type="checkbox"/> Drug distribution	<input type="checkbox"/> Soliciting prostitutes
<input type="checkbox"/> Manslaughter	<input type="checkbox"/> Drug possession	<input type="checkbox"/> Incest
<input type="checkbox"/> Vehicular homicide	<input type="checkbox"/> Theft	<input type="checkbox"/> Armed robbery
<input type="checkbox"/> Rape/Attempted rape	<input type="checkbox"/> Attempted theft	<input type="checkbox"/> Attempted robbery
<input type="checkbox"/> Sex with a minor	<input type="checkbox"/> Larceny	<input type="checkbox"/> Shoplifting
<input type="checkbox"/> Criminal sexual conduct	<input type="checkbox"/> Embezzlement	<input type="checkbox"/> Underage drinking
<input type="checkbox"/> Child molestation	<input type="checkbox"/> Arson	<input type="checkbox"/> Disorderly conduct
<input type="checkbox"/> Child abuse/neglect	<input type="checkbox"/> Probation violation	<input type="checkbox"/> Domestic violence
<input type="checkbox"/> Child endangerment	<input type="checkbox"/> Parole violation	<input type="checkbox"/> DWI
<input type="checkbox"/> Possession stolen property	<input type="checkbox"/> Aiding and abetting	<input type="checkbox"/> DUI
<input type="checkbox"/> Concealed weapon	<input type="checkbox"/> Fraud	<input type="checkbox"/> Vandalism
<input type="checkbox"/> Fleeing & eluding police	<input type="checkbox"/> Assault	<input type="checkbox"/> Truancy
<input type="checkbox"/> Leaving scene of accident	<input type="checkbox"/> Attempted assault	<input type="checkbox"/> Stalking
<input type="checkbox"/> Other: _____		

Current Probation/Parole Officer or Caseworker:

Name: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone () _____ - _____ Fax () _____ - _____

Current Probation/Parole Officer or Caseworker:

Name: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone () _____ - _____ Fax () _____ - _____

Attorney:

Name: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone () _____ - _____ Fax () _____ - _____

Family Information

Do you have any relatives already in our program? _____ No _____ Yes

If yes who: _____

Biological Mother's Name:

Name: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone () _____ - _____ Work () _____ - _____
Fax () _____ - _____ Cell () _____ - _____

Biological Father's Name:

Name: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone () _____ - _____ Work () _____ - _____
Fax () _____ - _____ Cell () _____ - _____

Spouse's Name:

Name: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone () _____ - _____ Work () _____ - _____
Fax () _____ - _____ Cell () _____ - _____

If divorced:

Name: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone () _____ - _____ Work () _____ - _____

Reason for break-up: _____

I have the following children:

Name: _____ Birthday: ___/___/___ Age: _____ Sex: _____
Name: _____ Birthday: ___/___/___ Age: _____ Sex: _____
Name: _____ Birthday: ___/___/___ Age: _____ Sex: _____
Name: _____ Birthday: ___/___/___ Age: _____ Sex: _____

I have the following siblings:

Name: _____ Birthday: ___/___/___ Age: _____ Sex: _____
Name: _____ Birthday: ___/___/___ Age: _____ Sex: _____
Name: _____ Birthday: ___/___/___ Age: _____ Sex: _____
Name: _____ Birthday: ___/___/___ Age: _____ Sex: _____
Name: _____ Birthday: ___/___/___ Age: _____ Sex: _____

Spiritual Information

Religious Preference: (Check only one)

_____ Assemblies of God _____ Pentecostal _____ Methodist
_____ Baptist _____ Presbyterian _____ Muslim
_____ Catholic _____ Lutheran _____ Evangelical Free
_____ Jewish _____ Evangelical Covenant _____ Other: _____

Personal walk with God:

I have accepted Jesus Christ as my Savior: _____ Yes _____ No Date: ___/___/___
I have been baptized in water: _____ Yes _____ No Date: ___/___/___
I have been filled with the Holy Spirit: _____ Yes _____ No Date: ___/___/___
I attend church _____ Often _____ Occasionally _____ Seldom _____ Never
I read the Bible _____ Often _____ Occasionally _____ Seldom _____ Never
I pray _____ Often _____ Occasionally _____ Seldom _____ Never

Church Affiliation:

Church Name: _____
How long have you attended this church? _____ Pastor: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone () _____ - _____
Fax () _____ - _____

Other Spiritual Practices:

_____ Satan worship _____ Witchcraft _____ Occults
_____ Ouija board _____ Séances _____ Palm reading
_____ Psychics _____ Fortune tellers _____ Voodoo
_____ Black magic _____ Animal sacrifices _____ Astrology

Describe God in your own words:

Describe how you believe God feels when he sees you:

What would you like God to do specifically for you?

- Do you want to be free from your bad habits? Yes No
- Do you want a normal relationship with your family? Yes No
- Do you want to be at peace with yourself and others? Yes No
- Do you want to be forgiven for everything in the past? Yes No
- Would you like to have a brand new start in life? Yes No
- Do you want God to help you change? Yes No
- Will you allow Him to let us help you change? Yes No

Financial Information

Income:

- I am presently employed Yes No \$ _____ Monthly Income
- I receive disability income Yes No \$ _____ Monthly Income
- I receive retirement income Yes No \$ _____ Monthly Income
- I receive SSI Yes No \$ _____ Monthly Income
- I receive workman's compensation Yes No \$ _____ Monthly Income
- I receive other unearned income Yes No \$ _____ Monthly Income
- I receive food stamps Yes No \$ _____ Monthly Income

Do you receive any other type of Government assistance? Yes No

If yes what type: _____

If yes what amount: \$ _____

Applicant Statement

I want to enter Teen Challenge's 12-15th month program because: (use other sheets if necessary)

I feel the main issues I need to work on are:

I certify that all the information here recorded is accurate and true to the best of my knowledge and has been fully completed by me in my own hand. I understand that any false or incomplete information may result in disqualification of any application for entrance.

Signed: _____ Date: _____

If forms completed in part or in whole by anyone other than applicant:

Name: _____ Relationship: _____

Reason why applicant was unable to complete application for himself: _____

Notice, it is hereby understood that Lansing Teen Challenge will not be held responsible for any personal property left, lost or stolen while in the Lansing Teen Challenge program. I agree that any property or money left at Lansing Teen Challenge over 14 days from my departure date, voluntarily or not, announced or unannounced becomes the property of Lansing Teen Challenge. It is further understood that, I release Lansing Teen Challenge from all financial responsibilities in case of accident, injury, illness, or other misfortune. I understand that there is a \$500.00 induction fee which is payable upon entry into the program and is non-refundable. I also understand that if I am dismissed from Lansing Teen Challenge or decide to leave the program I must leave within 24 hours. If I become belligerent, abusive, uncooperative, or threatening I must leave the facility immediately. It is important that medical, dental, business and legal needs be taken care of before entering the Lansing Teen Challenge program. If you have such needs that cannot be taken care of before entering Lansing Teen Challenge please call the center and explain your situation.

Signed: _____ Date: _____

Financial Requirements to Enter Teen Challenge

Dear Friend,

The staff at Teen Challenge is here to help you find the freedom from life controlling problems. Throughout the Bible we see Jesus offering forgiveness and hope to those seeking help. Jesus always offered his help free of charge. He greatly desired to see people have successful healthy lives.

At Teen Challenge we will never turn away anyone who cannot afford the help we provide.

However, the costs for our program are approximately \$875.00 per month per person. Though this is only a small fraction of other similar program costs we need help in order to pay these expenses.

We require each student to help us raise part of these costs. Some of the costs are raised through student training work programs like our Vehicle Donation Program. We feel that having students raise part of their recovery costs is helping them to become more self-sufficient and responsible. We also like to ask the family and friends of each student for help.

The following is a short list of costs:

\$500 **Induction Fee**
One time fee covers your costs for admission.

\$25 / month **Laundry Fee**
We provide laundry services for all residents.

These funds can be paid privately or raised from family and friends. We have attached a family and friends list that can be used to help raise support. Please fill out Family, Friends, and Church Sponsorship Sheet along with signing this form below.

A member of our office will be meeting with you in regards to this matter soon. Thanks!

Student Name: _____ Date: _____

Family, Friends, and Church Sponsorship Sheet



Teen Challenge does not charge for the services we provide. A resident is required to pay a one time induction fee to help provide for the financial costs to teach, feed, and reconstruct a life. However, every student is asked to provide names and phone numbers to anyone who can help provide for some of the program costs for his stay here on a monthly basis.

Name: _____ **Relationship:** _____
Occupation: _____ **Phone Number:** _____
Address: _____

Name: _____ **Relationship:** _____
Occupation: _____ **Phone Number:** _____
Address: _____

Name: _____ **Relationship:** _____
Occupation: _____ **Phone Number:** _____
Address: _____

Name: _____ **Relationship:** _____
Occupation: _____ **Phone Number:** _____
Address: _____

Name: _____ **Relationship:** _____
Occupation: _____ **Phone Number:** _____
Address: _____

Name: _____ **Relationship:** _____
Occupation: _____ **Phone Number:** _____
Address: _____

I, _____, hereby allow Lansing Teen Challenge to contact the above individuals on my behalf in order to obtain sponsorship funding to help with the cost of my stay in the program. I understand that Lansing Teen Challenge will only inform the above individuals that I am in fact currently a student in the program, and will not give out any confidential information in regards to my treatment or prognosis.

Signature: _____ **Date:** _____

Staff: _____ **Date:** _____



Work Skills or Training

Please check any of the following that you have had experience in. Then circle your skill level 1 = basic, 2 = average, 3 = above average, 4 = advanced.

Computer Skills:

Data Entry	1 - 2 - 3 - 4 - 5	Microsoft Publisher	1 - 2 - 3 - 4 - 5
Microsoft Word	1 - 2 - 3 - 4 - 5	Networking TCP/IP	1 - 2 - 3 - 4 - 5
Microsoft Excel	1 - 2 - 3 - 4 - 5	MS/DOS	1 - 2 - 3 - 4 - 5
Microsoft Access	1 - 2 - 3 - 4 - 5	Internet	1 - 2 - 3 - 4 - 5
Microsoft Outlook	1 - 2 - 3 - 4 - 5	Others	

Construction/Maintenance:

Framing & Drywall	1 - 2 - 3 - 4 - 5	Roofing	1 - 2 - 3 - 4 - 5
Floor Covering	1 - 2 - 3 - 4 - 5	Windows & Doors	1 - 2 - 3 - 4 - 5
Electrical	1 - 2 - 3 - 4 - 5	Painting	1 - 2 - 3 - 4 - 5
Plumbing	1 - 2 - 3 - 4 - 5	Others	

Mechanic Skills:

Oil Change	1 - 2 - 3 - 4 - 5	Alignments	1 - 2 - 3 - 4 - 5
Tires	1 - 2 - 3 - 4 - 5	Breaks	1 - 2 - 3 - 4 - 5
Electrical	1 - 2 - 3 - 4 - 5	Engine	1 - 2 - 3 - 4 - 5
Tune Up	1 - 2 - 3 - 4 - 5	Others	

Musical Abilities:

List any instruments you play			
Singing Ability	1 - 2 - 3 - 4 - 5	Choir Directing	1 - 2 - 3 - 4 - 5

Cooking/Kitchen Skills

Please list	

Landscaping:

Please list	