purehope
FOUNDATION

Restorative Development Internship

INTERNSHIP APPLICATION

Personal Information

Last Name		First Name			
Date of Birth		Spouse Name			
ID number	List: type of ID, State & Number	Social Security			
Address		Name of Current Program			
City		State		Zip Code	
Safe Telephone Number					
Age		Height		Weight	
Religion		Race/Ethnicity			
Marital Status	Single	Married	Divorced	Widowed	

Do you consider yourself to be:
☐ Heterosexual (straight) ☐ Bisexual ☐ Homosexual (Gay/Lesbian) ☐ Transgender ☐ Unsure

Emergency Contact Name		Relationship	
Emergency Phone #		Secondary #	

On a scale of 1-10, 1 being the lowest, how would you rate your physical health?
1 2 3 4 5 6 7 8 9 10

Circle last year completed:
Primary: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 +

Do you have your GED or High School Diploma? ☐ Yes ☐ No

Do you have a current drivers license? ☐ Yes ☐ No

Family History

Were you involved in the foster care system?	☐ Yes	☐ No
Do you know your mother or father?	☐ Yes	☐ No
Was there anyone in your family who abused you? (verbally, physically, or emotionally)	☐ Yes	☐ No
Was there anyone in your family who sexually abused you?	☐ Yes	☐ No
Are you currently in contact with anyone from your family?	☐ Yes	☐ No
Will your family be a good support group for you while you are here?	☐ Yes	☐ No
Do you have any kids?	☐ Yes	☐ No

Legal History		
Have you ever been arrested?	☐ Yes	☐ No
Have you ever done jail time?	☐ Yes	☐ No
Are you on formal probation or parole?	☐ Yes	☐ No
Are you on Summary Probation?	☐ Yes	☐ No
Are you court ordered here?	☐ Yes	☐ No
Do you have any legal charges pending?	☐ Yes	☐ No
Do you think you may have any outstanding warrants?	☐ Yes	☐ No
Do you have any other pending legal matters that would require your attention within the next 90 days?	☐ Yes	☐ No

Drug History		
Have you ever used drugs?	☐ Yes	☐ No
Have you been sober for at least 90 days?	☐ Yes	☐ No
Have you ever sold drugs?	☐ Yes	☐ No

Medical History		
Do you have any Allergies?	☐ Yes	☐ No
Do you have any physical handicaps?	☐ Yes	☐ No
Do you wear glasses?	☐ Yes	☐ No
Do you wear contacts?	☐ Yes	☐ No
Are you on a special diet or special medical care?	☐ Yes	☐ No
Have you ever been:		
Diagnosed with ADD or ADHD?	☐ Yes	☐ No
Diagnosed with any Mental Disorder?	☐ Yes	☐ No
Diagnosed with Tuberculosis?	☐ Yes	☐ No
Diagnosed with Hepatitis A, B, or C?	☐ Yes	☐ No
Diagnosed with Herpes?	☐ Yes	☐ No
Diagnosed with any STD?	☐ Yes	☐ No
Diagnosed with Body Lice?	☐ Yes	☐ No
Diagnosed with High Blood Pressure?	☐ Yes	☐ No
Diagnosed with any other illnesses?	☐ Yes	☐ No
Do you currently have any chronic medical conditions not listed above that require regular visits to the doctor?	☐ Yes	☐ No
Are you currently taking any regular medications?	☐ Yes	☐ No
Are there any medications that your Doctor said you should be taking that you aren't taking?	☐ Yes	☐ No
Do you have anything that is contagious?	☐ Yes	☐ No
Have you ever been diagnosed with any mental condition?	☐ Yes	☐ No
Have you ever or are currently taking Psychotropic Medications? ☐ Yes ☐ No	☐ Yes	☐ No

Sexual History		
Are you currently sexually active?	☐ Yes	☐ No
Do you have any physical handicaps?	☐ Yes	☐ No
Have you ever been the victim of sexual abuse?	☐ Yes	☐ No
Do you struggle with masturbation?	☐ Yes	☐ No
Have you ever been involved in prostitution?	☐ Yes	☐ No
Have you had more than one pimp?	☐ Yes	☐ No
Exploitation: Have you ever experienced the following:		
1. Sex Trafficking (as a minor – age 17 or younger)	☐ Yes	☐ No
2. Forced Prostitution (as an adult – age 18 or older)	☐ Yes	☐ No
3. Forced Labor	☐ Yes	☐ No
4. Servile Marriage	☐ Yes	☐ No
5. Smuggling	☐ Yes	☐ No
6. Has your perpetrator/ trafficker ever looked for you/ found you?	☐ Yes	☐ No
7. Have you contacted your trafficker?	☐ Yes	☐ No
8. Is there a criminal investigation pending?	☐ Yes	☐ No
9. Has trafficker been convicted?	☐ Yes	☐ No
10. Have you obtained certification that you have been trafficked?	☐ Yes	☐ No
11. Stripping/ Exotic Dancing	☐ Yes	☐ No
12. Escort Services	☐ Yes	☐ No
13. Massage Services	☐ Yes	☐ No
14. Porn	☐ Yes	☐ No
15. Are you exploited on Facebook? (Please provide names)	☐ Yes	☐ No
16. Social Media site? (Please Provide Names)	☐ Yes	☐ No
17. Backpage (Please Provide Names)	☐ Yes	☐ No
18. Instagram?	☐ Yes	☐ No

PARTICIPANT RELEASE STATEMENT

I, _____, understand that my acceptance as a participant in the Pure Hope Foundation Program ("Program") requires the following:

1. I am a volunteer participant and not an employee of Pure Hope Foundation ("PHF") or any of its affiliates. I further understand that under no circumstances can Pure Hope Foundation or any of its affiliates be under any obligation to me.
2. I understand that my admission and continued residence in PHF is dependent upon my needing such assistance and my willingness to help myself and others so situated, including the voluntary performance of such duties as may be assigned to me.
3. I am aware of the hazards and risks to my person and property associated with being a part of this Program. Such hazards and risks include, but are not limited to, death, injury by accident, disease, weather conditions, inadequate medical services and supplies, criminal activity, and random acts of violence. I voluntarily assume all risks of death, injury, and illness associated with such risks, and any damage to my personal property. I further understand that Pure Hope Foundation or any of its affiliates may not have any insurance coverage that would apply in the event of my death, illness, injury, or damage to my person or property that may occur during my participation in the Program. If I desire insurance coverage, I understand that I am responsible for obtaining and paying for the cost of such insurance.
4. I release Pure Hope Foundation and its affiliates, agents, officers, directors, employees and volunteer staff from any liability whatsoever arising as a result of death, injury, or illness that I may suffer as a result of my participation in the Program.
5. I attest and certify that I have no medical conditions that would prevent me from performing my duties as a volunteer participant.
6. I expressly waive any defense to the enforcement of any provision of this commitment arising from a claim of lack of consideration and warrant that this commitment constitutes a legal valid and binding obligation upon me enforceable against me in accordance with its terms.
7. I expressly agree that this assumption of risk agreement is intended to be as broad and inclusive as permitted by law. I further state that **I HAVE CAREFULLY READ THE FOREGOING ASSUMPTION OF RISK AND UNDERSTAND ITS CONTENTS, AND I VOLUNTARILY SIGN THIS RELEASE AS MY OWN FREE ACT. THIS IS A LEGAL DOCUMENT AND I UNDERSTAND THAT I HAVE THE OPPORTUNITY TO CONSULT WITH AN ATTORNEY BEFORE SIGNING IT.**

Dated this _____ day of _____ 20 _____.

_____	_____
Participant's Signature	Witness's Signature
_____	_____
Participant's Printed Name	Witness's Printed Name

PURE HOPE RESTORATIVE CARE PROGRAM
PARTICIPANT AGREEMENT

I, _____, understand that my acceptance as a participant in the Pure Hope Foundation Restorative Care Program requires the following:

1. **HOUSE PROCEDURES, MORAL STANDARD, AND WITHDRAWAL FROM SUBSTANCE**. I have read and understood all House Procedures provided to me, and understand that such House Procedures may be amended upon the Program's discretion, with or without notice. Accordingly, I agree to abide by all Program's policies including but not limited to the House Procedures as given to me.

   In addition, I agree to honor the standards of the Bible when it comes to dating & choose not to participate in sexual activity outside of marriage. Furthermore, I understand that the Program is drug and alcohol free, but does not serve as a detoxification facility. Accordingly, I agree to withdraw from any and all substance dependence voluntarily and without the use of medication. I acknowledge that Pure Hope Foundation is not a clinical mental health facility and therefore not equipped to serve participants withdrawing from substance abuse, diagnosed with severe mental illness, or taking heavy anti-psychotic medications.

2. **MEDICAL RELEASE.** I hereby authorize the Program to make arrangements for any emergency medical assistance that may be required due to any illness or injury on my part.

3. **THE PURE HOPE FOUNDATION HIV POLICY.** The Pure Hope Foundation Restorative Care Program does not discriminate against those who are HIV Positive in its intake procedures. Because a large number of IV drug users have been infected by the HIV Virus, at any given time there may be one or more individuals in the program that are HIV Positive. This program does not require individuals who are HIV Positive to notify other individuals in the program that are HIV Positive.

   Staff Members are forbidden without written permission of the individuals to discuss the disposition of any individuals on his/her caseload; other than those individuals that are involved in the treatment process.

   The Program is not a medical care facility and is unable to provide twenty-four hour on-site medical supervision. Therefore, all individuals entering the program must be in good health and able to participate in all activities in the program. If an individual's health deteriorates to the point where he/she is no longer able to participate in the daily activities of the program, or medical condition requires twenty-four hour medical supervision, that person should leave the Program.

   HIV Positive individuals who have family members or friends who could have possibly contracted the virus from them shall notify them immediately.

   Any HIV Positive individuals that intentionally put another person at risk of being infected with HIV virus should be immediately dismissed from the program.

4. **SPIRITUAL REQUIREMENTS.** I understand that the Program is a Christian based ministry program to assist people with life controlling problems. Through my participation in this program, I agree to submit to the Program's expectations and attend the Program's spiritual activities.

5. **CONSENT TO DRUG TESTING AND ROOM SEARCHES.** I understand that the Program is a drug and weapon free facility for the safety and well-being of all its residents, employees, and volunteers. Accordingly, by my participation and consent below, **I hereby voluntarily consent to all drug tests on myself and room searches of my living quarters upon request.**

   I understand that the results of my drug tests, if any, will only be disclosed to the Pure Hope Restorative Care Program and all legal authorities the Pure Hope Foundation deems necessary. I understand that if I am tested positive for any banned drugs that are listed in the Pure Hope Foundation's Drug Testing and Room Search Procedure, the staff may terminate my participation in the Program. Furthermore, the Pure Hope Foundation may terminate my participation if there are any drugs, banned items or weapons found in my living quarters or on my person.

Dated this _____day of _____ 20 _____.

_____ _____

Participant's Signature Witness's Signature

_____ _____

Participant's Printed Name Witness's Printed Name

EQUAL HOUSING OPPORTUNITY

purehope FOUNDATION

Request/Authorization to Release Confidential Records and Information

Name:_____ DOB:_____ Soc. Sec.:_____

Address:_____City, State, Zip:_____

CIRCLE THE APPROPRIATE SELECTION:
I authorize, the Pure Hope Foundation to obtain information form:

_____

Name of Provider / Facility Address

_____

City, State, Zip Phone Fax

PURPOSE OF THIS REQUEST

- ○ Intake application review
- ○ Treatment Planning

These records concern the time between_____ and _____
SPECIFIC INFORMATION AUTHORIZED:

- ○ Progress Notes
- ○ Treatment Plans/Summary
- ○ Test Results
- ○ Mental Health Evaluation
- ○ Psychological and/or Neuropsychological Assessment Report
- ○ Minute Orders

HIVE-RELATED INFORMATION AND DRUG/ALCOHOL INFORMATION contained in these records will NOT be released unless indicated here: _____

I have had explained to me and fully understand this request/authorization to release records, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is voluntary on my part. I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. The information disclosed may be used in connection with my/the patient's treatment. I understand that I may take back this consent at any time within 90days, except to the extent that action based on this consent has already been taken. This consent will be valid no longer than is reasonably necessary to meet the purposes stated above, and not to exceed 1 year. If the person/organization that receives this information is not health care provider/health insurer, the information may no longer be protected by federal privacy regulations. I also understand that I am entitled to a copy of this authorization.

_____ _____ _____

Signature of Resident **Name of Resident** **Date**

DISCLOSURE and AUTHORIZATION – BACKGROUND INVESTIGATION

In connection with my application for a residential internship with Pure Hope Foundation ("Client"), I understand that a "consumer report" and/or "investigative consumer report", as defined by the Fair Credit Reporting Act (15 U.S.C. § 1681), will be requested by Client for residential internship, from Protect My Ministry, Inc., ("Protect My Ministry"), a consumer reporting agency as defined by the Fair Credit Reporting Act. These reports may include information as to my character, general reputation, personal characteristics or mode of living, whichever are applicable. They may involve interviews with sources such as my neighbors, friends or associates. The report may also contain information about me relating to my criminal history, credit history, driving and/or motor vehicle records, social security number verification, verification of education or employment history, worker's compensation (only after a conditional job offer) or other background checks. Such reports may be obtained at any time after receipt of this Disclosure and Authorization and if I am hired or serve as a volunteer, whichever is applicable, throughout the course of my residential internship, as permitted by law and unless revoked by me in writing. Client also reserves the right to share my report with any third-party with whom I will be placed to work or volunteer with as a residential intern. I understand that I have the right, upon written request made within a reasonable amount of time after the receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report to Protect My Ministry, Inc., 14499 N. Dale Mabry Hwy., Suite 201 South, Tampa, FL 33618 or 1-800-319-5581. For information about Protect My Ministry's privacy practices, see www.protectmyministry.com.

Acknowledgement and Authorization

By signing below, I authorize Client or its authorized agents to obtain or prepare consumer reports or investigative consumer reports about me. I acknowledge receipt of a copy of the federal notice entitled *A Summary of Your Rights under the Fair Credit Reporting Act* and certify that I have read this Disclosure and Authorization as well as the summary document explaining my rights under the Fair Credit Reporting Act.

_____ TODAY'S DATE_____
Signature

LAST NAME _____FIRST NAME_____MIDDLE NAME/INITIAL _____

HOME ADDRESS_____
_____

CITY _____ COUNTY_____ STATE ____ ZIP_____

_____ _____ _____
SSN D/L or STATE ID STATE ISSUED

_____
EMAIL ADDRESS

For identification purposes only, please provide FULL DOB: _____

Please List Other Names Used _____