



P.O. Box 580460 | Tulsa, OK 74158-0460  
918.949.HOPE (4673) | cceok.org

## MADONNA HOUSE APPLICATION

### General Applicant Information

**Date:** \_\_\_\_\_

**Applicant:** \_\_\_\_\_ **SSN#** \_\_\_\_\_  
(Last) (First) (Middle)

**Date of birth:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Email address:** \_\_\_\_\_

Other names you have used: \_\_\_\_\_

**Marital status:**

- \_\_\_ Married
- \_\_\_ Single
- \_\_\_ Separated
- \_\_\_ Divorced
- \_\_\_ Widowed

**Education: (check highest level of education that applies)**

- \_\_\_ Some High School
- \_\_\_ H.S. diploma/GED
- \_\_\_ Some college
- \_\_\_ College degree or higher

Educational Goal (GED, CNA, cosmetology, etc.): \_\_\_\_\_

Have you ever served in the U.S. Military? \_\_\_ Yes \_\_\_ No

If yes, provide dates of service: \_\_\_\_\_ to \_\_\_\_\_

Are you currently pregnant? Yes/No

**Baby's due date:** \_\_\_\_\_ **or birth date:** \_\_\_\_\_

**Household members currently living with you:**

<u>Last name</u>	<u>First Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Other Children:**

(Please provide information about any other children who are not currently living with you, including with whom they are living)

<u>Last Name</u>	<u>First</u>	<u>Age</u>	<u>Relationship</u>	<u>Where Living</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please describe the issue(s) leading you to apply for housing at Madonna House:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please provide the following information concerning the baby's father:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Age: \_\_\_\_\_

**When was the last time you had contact with this baby's father?** \_\_\_\_\_

**What is the current status of your relationship with the baby's father? (circle one)**

Together      Not Together      Divorced      Separated      Uncertain

**Is there a history of drug abuse related to the baby's father or his friends or relatives? (circle one)**

Yes                      No                      Uncertain

**Is there a history of physical or verbal abuse related to the baby's father or his friends or relatives? (circle one)**

Yes                      No

**Is the baby's father planning to participate in the baby's life? (circle one)**

Yes                      No                      Uncertain

## APPLICANT RESIDENTIAL HISTORY

**Current Address:**

**Address:** \_\_\_\_\_  
(Street)                      (City)                      (State)    (Zip)    (Phone. Include area code)

Dates of Residency: \_\_\_\_\_ to \_\_\_\_\_

**Is current address the home of: Self/Friend/Relative/Motel/Shelter (Circle one)**

**If yes, name of Friend/Relative/Motel/Shelter:** \_\_\_\_\_

**Who lives with you at this address?**

Name	Relationship
_____	_____
_____	_____
_____	_____

**Prior Addresses**

**(Please include information for the 5 years prior to submitting this application)**

1) Previous address: \_\_\_\_\_  
(Street)                      (City)                      (State)    (Zip)

Landlord: \_\_\_\_\_ Phone: \_\_\_\_\_

Dates of Residency: \_\_\_\_\_ to \_\_\_\_\_

**Who lived with you at this address?**

Name	Relationship
_____	_____
_____	_____
_____	_____

2) Previous address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Landlord: \_\_\_\_\_ Phone: \_\_\_\_\_

Dates of Residency: \_\_\_\_\_ to \_\_\_\_\_

**Who lived with you at this address?**

Name	Relationship
_____	_____
_____	_____
_____	_____

(If additional space is needed, please use the back of this sheet).

Have you ever lived in other shelters or transitional housing, lived as an adult rent-free in another person's home and/or subsidized housing? Yes \_\_\_\_\_ No \_\_\_\_\_ (If Yes, indicate below)

Name of person, shelter, etc.: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (Phone. Include area code)

Dates of Residency: \_\_\_\_\_ to \_\_\_\_\_

(If additional space is needed, please use the back of this sheet).

**I have found myself homeless in the past:**

\_\_\_\_\_ this is the first time

\_\_\_\_\_ 1-2 times

\_\_\_\_\_ 3-5 times

\_\_\_\_\_ I have never had a place of my own as an adult; I couch surf.

\_\_\_\_\_ I have never had a place of my own as an adult; I have had a roommate.

I have applied for:

\_\_\_\_\_ Tulsa Public Housing-Date of application: \_\_\_\_\_

\_\_\_\_\_ Section 8 Voucher-Date of application: \_\_\_\_\_

\_\_\_\_\_ Low-income apartment-Date of application: \_\_\_\_\_

## APPLICANT FINANCIAL HISTORY

Do you have any unpaid debts? (indicate amount)

Utilities \$ _____	Rent \$ _____	Bank loans \$ _____
Car Loans \$ _____	Education \$ _____	Court fines \$ _____
Child Support \$ _____	Medical Bills \$ _____	Other \$ _____

In addition to employment income, do you receive any of the following? (check all that apply)

Disability/SSI \$ \_\_\_\_\_ Child Support \$ \_\_\_\_\_ Food stamps \$ \_\_\_\_\_ WIC \_\_\_\_\_

# APPLICANT EMPLOYMENT HISTORY

(Please include information for the 5 years prior to submitting this application)

**Current Employer:**

Place of Employment: \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Street) (City) (State) (Zip) (Include Area Code)

Supervisor: \_\_\_\_\_ Wage/Salary: \_\_\_\_\_

Date(s) of Employment: \_\_\_\_\_ Number of hours worked/week: \_\_\_\_\_

Total pay per month: \$ \_\_\_\_\_ Pay Days: \_\_\_\_\_

**If you are not currently employed, please check here: \_\_\_\_\_**

**Previous Employer:**

Place of Employment: \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Street) (City) (State) (Zip) (Include Area Code)

Supervisor: \_\_\_\_\_ Wage/Salary: \_\_\_\_\_

Dates of Employment from: \_\_\_\_\_ to \_\_\_\_\_ Why did you leave? \_\_\_\_\_

**Previous Employer:**

Place of Employment: \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Street) (City) (State) (Zip) (Include Area Code)

Supervisor: \_\_\_\_\_ Salary: \_\_\_\_\_

Dates of Employment from: \_\_\_\_\_ to \_\_\_\_\_ Why did you leave? \_\_\_\_\_

**If additional space is needed, please use the back of this sheet.**

# APPLICANT HEALTH HISTORY

Are you currently pregnant? Yes/No Due date: \_\_\_\_\_

Are there any complications with this pregnancy? Are you considered High Risk? Yes/No

If yes, please describe: \_\_\_\_\_

Are you enrolled in SoonerCare? Yes/No Are you currently under a physician's care? Yes/No

If yes, indicate the following:

**Physician:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

If you are not pregnant, what is the birth date of your youngest child? \_\_\_\_\_

**Pediatrician:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Street) (City) (State) (Zip) (Include area code)

**Indicate the number of previous pregnancies:** \_\_\_\_\_

Of those pregnancies, how many were: Miscarriage(s) \_\_\_\_\_ Abortion(s) \_\_\_\_\_ Adoption(s) \_\_\_\_\_

**Medical Issues:**

**Please list any medical conditions/disabilities with which you have been diagnosed or for which you are receiving treatment:**

---

---

---

**Please list any medical conditions/disabilities with which your child has been diagnosed or for which your child is receiving treatment:**

---

---

---

**Mental Health:**

**1. Have you or any individual listed on Page 1 of this application seen a mental health provider in the past 10 years? If yes, please provide the following information regarding those providers:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
           (Street)           (City)           (State)           (Zip)           (include area code)

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
           (Street)           (City)           (State)           (Zip)           (include area code)

**2. Are you experiencing any of the following symptoms/problems? (please circle all that apply)**

- |   |  |                                    |
|---|--|------------------------------------|
| <b>Moodiness</b>  | <b>Conflicts with others</b>   | <b>Changes in/trouble sleeping</b> |
| <b>Uncontrolled anger</b>   | <b>Impulsivity</b>   | <b>Lack of friends/loneliness</b>  |
| <b>Sadness</b>  | <b>Feelings of worthlessness</b>   | <b>Nervousness/anxiety</b>         |
| <b>Obsessive</b>  | <b>Unreasonable fear/panic</b>   | <b>Discomfort in crowds</b>        |
| <b>Argumentative</b>  | <b>Changes in eating patterns</b>  | <b>Suicidal Thoughts</b>           |
| <b>Visual hallucinations<br/>(seeing things that are not present)</b> | <b>Auditory hallucinations<br/>(hearing things that are not present)</b> | <b>Homicidal Thoughts</b>          |

**Please list any mental health conditions with which you have been diagnosed or for which you are receiving treatment:**

<b>Condition</b>	<b>Date of Diagnoses</b>	<b>Receiving Treatment?</b>	<b>Hospitalizations due to condition? Include dates.</b>
		Yes/No	Yes/No Dates: _____
		Yes/No	Yes/No Dates: _____
		Yes/No	Yes/No Dates: _____
		Yes/No	Yes/No Dates: _____

Please complete the following chart concerning medications currently prescribed to you:

Medication	Condition for which medication prescribed	When did you begin taking this medication?

## SPIRITUALITY/MOTIVATION

Do you attend Church? Y/N                      Often                      Occasionally                      Seldom                      Never

Do you consider yourself a member of a particular religion? Y/N                      Religion: \_\_\_\_\_

Home Church: \_\_\_\_\_

As part of living at Madonna House, you are required to attend church services of your choice on Sundays (or Saturday evening). Will you have trouble agreeing to those terms? Y/N

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

### Family and Relationships History:

1. Is there a family history of addictions? \_\_\_Yes    \_\_\_No

2. If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

3. How would you describe your relationship with your children?

\_\_\_Good \_\_\_Fair \_\_\_Poor \_\_\_Close \_\_\_Stressful \_\_\_Distant \_\_\_Other \_\_\_\_\_

4. What do you and your family do for fun?

\_\_\_\_\_

5. Identify the people who are supportive of you and your family: (Check all that apply)

\_\_\_Parents \_\_\_Other family \_\_\_Friends \_\_\_\_\_ Church group \_\_\_\_\_ Other



# SUBSTANCE USE HISTORY

## Tobacco:

1. Have you ever used any forms of tobacco?  Yes  No
2. If yes, what form(s) of tobacco have you use in the past? (check all that apply)  
 Cigarettes  Cigars  E-cigarettes  Chewing Tobacco  Other
3. How many times on an average day do you use tobacco? \_\_\_\_\_
4. Have you ever been involved in a program to help you quit using tobacco?  
 Yes  No
5. If so, which self-help group was used? \_\_\_\_\_

## Alcohol

1. Have you previously used alcohol?  Yes  No
2. If yes, age of first use: \_\_\_\_\_
3. Have you used alcohol in the past 30 days?  Yes  No
4. Frequency of alcohol use (check one):  
 less than once/month  
 monthly  
 weekly  
 several times/week  
 daily  
 several times/day
5. When you use alcohol, how many drinks to you usually consume (check one):  
 one  
 two – three  
 four – five  
 more than five
6. Have you previously been involved in a program to help you stop using alcohol?  
 Yes  No
7. If yes, indicate the name of the program and provide approximate dates of attendance:

Name of Program	Start Date	End Date

## Drug Use

1. Have you previously used illegal drugs?  Yes  No
2. If yes, please list:  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Have you used in the past 30 days?  yes  No
4. Approximate date of last use: \_\_\_\_\_ Drug(s) used: \_\_\_\_\_
5. Describe frequency of use (check one):  
 less than once/month  
 monthly  
 weekly  
 several times/week  
 daily  
 several times a day

6. Have you been involved in a program to help you quit using drugs? \_\_\_Yes \_\_\_No  
 7. If yes, indicate the name of the program and provide approximate dates of attendance:

Name of Program	Start Date	End Date

## APPLICANT LEGAL HISTORY

1. Have you ever been arrested and/or charged with a crime? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 2. If yes, please indicate the charge(s) and approximate date(s) of those charges:

Charge/Crime	Date of Charge	Conviction?
		Yes/No/Not yet decided
		Yes/No/Not yet decided
		Yes/No/Not yet decided
		Yes/No/Not yet decided

3. Are you currently or have you ever been on probation? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 4. Do you currently or have you ever had a case before DHS? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If yes, please describe the circumstances of your case, and indicate whether and how it was resolved or whether it is still pending.

---



---



---

**Are you or have you ever been affected by any of these situations? (Check all that apply)**

\_\_\_ Domestic Violence    \_\_\_ Substance Abuse    \_\_\_ Eviction    \_\_\_ Child custody (Removal)

**Please describe:**

---



---



---



---

Is this a current issue? Y / N

When was the last time these incidents occurred? \_\_\_\_\_

**PLEASE READ CAREFULLY AND INITIAL THE FOLLOWING**

\_\_\_\_\_ I understand that if I do not abide by the rules of Catholic Charities then I will not be able to reside at the Madonna House.

\_\_\_\_\_ I understand that there will be mandatory meetings, classes, and appointments, including weekly counseling, required if I am invited and decide to stay at the Madonna House.

\_\_\_\_\_ I understand that I may have to undergo drug/alcohol testing during my stay at Madonna House.

**All of the above information is true and correct to the best of my knowledge.**

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Coordinator Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Required Documentation:**

**Do not enclose documentation with your application. These are required at the time of move-in.**

- \_\_\_ **Birth Certificate for each individual**
- \_\_\_ **Social Security cards for each individual**
- \_\_\_ **Copy of driver's license or valid State I.D. for each person as applicable**
- \_\_\_ **SoonerCare or other health insurance cards**
- \_\_\_ **Copy of bank statements (checking and savings)**
- \_\_\_ **Current copies of Pay stubs for past 30 days**
- \_\_\_ **W-2**
- \_\_\_ **Auto Insurance Verification**

**So that we may serve you better:**

Applicant Clothing Sizes:

Baby's clothing sizes:

Shirt Size: _____	Shirt or Onsie Size: _____
Pant Size: _____	Pant Size: _____
Underwear Size: _____	Sock Size: _____
Bra Size: _____	Shoe Size: _____
Shoe Size: _____	Diaper Size: _____

Food Allergies: \_\_\_\_\_

Please list any immediate needs for food, clothing, or other items:

- ✓ \_\_\_\_\_
- ✓ \_\_\_\_\_
- ✓ \_\_\_\_\_
- ✓ \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following reflective questions.

1. Why have I chosen the Madonna House as the place I would like to complete my pregnancy and/or begin a new life with my baby?

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

2. What do I hope to accomplish as a resident of Madonna House?

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---



P.O. Box 580460 | Tulsa, OK 74158-0460  
 918.949.HOPE (4673) | cceok.org

## Authorization for Disclosure of Confidential Information

I, \_\_\_\_\_, authorize the disclosure and use of my personal information as it relates to the following agencies/persons:

I authorize the following person(s) and/or organization(s) to disclose and/or receive my personal, confidential information:

Name of Individual(s) and/or Organization(s)	Contact Information

I further authorize the below person(s) and/or organization(s) to receive information from the above stated (the below authorized may also disclose my information, as necessary, to the above authorized person(s) and/or organization(s):

Name of Individual(s) and/or Organization(s)	Contact Information
Catholic Charities Transitional Living	918-508-7140

**Specific Information that may be disclosed by the above authorized parties:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fact Sheet                           | <input type="checkbox"/> Social Service Reports      | <input type="checkbox"/> Consultation         |
| <input type="checkbox"/> Mental Health Information            | <input type="checkbox"/> Lab Reports                 | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Medical Records                      | <input type="checkbox"/> Psychiatric Records         | <input type="checkbox"/> Discharge Summary    |
| <input type="checkbox"/> Counseling Records                   | <input type="checkbox"/> Drug/Alcohol Care/Treatment | <input type="checkbox"/> Felony Record(s)     |
| <input type="checkbox"/> DHS Progress Reports                 | <input type="checkbox"/> Court Documents             | <input type="checkbox"/> WIR Documents        |
| <input type="checkbox"/> Madonna House Progress Reports       |  | <input type="checkbox"/> DVIS Records         |
| <input type="checkbox"/> My Children’s Records, as applicable |  | <input type="checkbox"/> Contact Information  |
- \_\_ All of my information including, but not limited to, anything referenced above***

**The above information is authorized to be disclosed for the following purpose(s):**

- |   |   |
|---|---|
| <input type="checkbox"/> At the request of the named individual(s) and/or organization(s) | <input type="checkbox"/> Service Planning         |
| <input type="checkbox"/> Continued Treatment  | <input type="checkbox"/> DHS Case                 |
| <input type="checkbox"/> Legal Action   | <input type="checkbox"/> Child Custody Hearing(s) |
| <input type="checkbox"/> Other (if other, please specify): _____                          | <input type="checkbox"/> DVIS Case                |
|   | <input type="checkbox"/> Family Request(s)        |

**This authorization shall be valid until:**

   Six months from the date of this signed document

   One year from the date of this signed document

   Until the following date: \_\_\_\_\_

**Right to Revoke**

I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that Catholic Charities and/or Madonna House have already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to:

*Privacy/Compliance Officer  
Catholic Charities  
2450 N. Harvard Ave.  
Tulsa, OK 74115*

I understand that my services/treatment cannot be conditioned on whether I sign this authorization.

I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) and/or organization(s) that I authorize to receive my confidential information are not subject to federal and state information privacy laws, subsequent to disclosure by such person(s) and/or organization(s) may not be protected by those laws.

I understand that this information disclosed may include, when applicable, information relating to communicable or venereal disease (including, but not limited to, diseases such as hepatitis, syphilis, gonorrhea) and the Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex).

I understand that alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act (“HIPAA”), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I am entitled to receive a copy of this authorization.

\_\_\_\_\_  
Client Signature (person providing the authorization)

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Client Representative Signature (if applicable – read below under “Translation”)

\_\_\_\_\_  
Date of Signature

**TRANSLATION:** This is to certify that the above Authorization has been read to the client (or client representative) in his/her native language. All representatives which appear in the Authorization were understood and authorized by the client (or representative).

\_\_\_\_\_  
Interpreter Signature

\_\_\_\_\_  
Date of Signature



P.O. Box 580460 | Tulsa, OK 74158-0460  
918.949.HOPE (4673) | cceok.org

## Release of Information

Date: \_\_\_\_\_

I, \_\_\_\_\_, give permission to Catholic Charities

of Eastern Oklahoma to receive from \_\_\_\_\_

records pertaining to \_\_\_\_\_.

These will be kept in my confidential Personal File and are used only as references.

All records should be sent to: Catholic Charities/Transitional Living Coordinator  
2450 N. Harvard Avenue  
Tulsa, OK 74158-0460

Or fax to: (918) 584-4588

Thank you for your prompt response to this request.

Sincerely,

\_\_\_\_\_

(Applicant's signature)

## Madonna House - Main Rules:

1. **Curfew** (back on campus)
  - a. Weekdays: 5:30 pm to 6:00 am
  - b. Weekends: 9:30 pm to 6:00 am
2. **Phone policy:** no phone use during meetings or classes.
3. **Chores and room maintenance:** every week, some chores will be assigned to you. Neglect of chores and failure to pass the room inspection will result in probation, up to dismissal from the program.
4. **Attendance:** you should participate in all required meetings at all times (counseling appointments, classes, communal activities, dinner time). Weekly church attendance is required; you are encouraged to attend the church of your choice. Participation requires you to be fully engaged during the sessions. Neglecting mandatory classes will be a cause for dismissal from the program.
5. **Transportation:** the primary way of transportation for Madonna House residents is the Tulsa Public Transit System (bus) and SooneRide. Under certain circumstances, you may receive a taxi voucher or an approval for rides by volunteers or Care Assistants. This request should be made at least 24 hrs in advance office. A Care Assistant will provide transportation once a week for grocery shopping.
6. **Family time:** You are allowed to spend family time during the weekend (not overnights) with approved contacts. Your case manager will be happy to explain to you who are considered approved contacts. In some special circumstances you will be allowed to stay for overnights with your approved contacts (Thanksgiving, Christmas Eve, family events). Unexpected visits are not allowed. Please, inform your case manager in advance about your plans.
7. **Day time activities:** Must participate in school activities (GED, TCC, etc) or volunteer for at least 5 hrs a week at all times. Work is not required during your pregnancy, but is allowed with prior approval of your Case Manager (just daytime time shift). You should plan your day with assistance from a Care Assistant and your case manager to make sure you are spending your time in productive activities; final approval will be provided by your case manager. Post-partum mothers are expected to work part-time or full-time. If a resident refuses to keep herself busy during the day time, and is spending most of the day resting or watching TV, this will be a cause for dismissal.
8. **Zero Tolerance policy for drugs and alcohol.** A positive result of drugs or alcohol consumption will be cause of immediate dismissal from the program (less than 24 hrs) You have to be open to take random UA's for drugs and alcohol and agree to random room inspections by Care Assistants at any time and any day. If you are asked to test, you should do it immediately. Refusing room inspections or refusing to take a drug/alcohol test will be considered a "positive result" and will result in immediate dismissal. Smoke breaks are allowed outside of required activities (classes, community meals, etc.) but you have to do this outside of Catholic Charities property, since this is a smoke free campus. If you are interested in getting involved in smoking cessation programs for the benefit to your baby, we will be happy to assist you with this task.
9. **Proper behavior:** Kind, honest, proactive and non-aggressive behavior at all times. We will not tolerate any kind of cursing or aggressive reactions (physical or verbal) against staff, volunteers or other residents of Madonna House or St. Elizabeth Lodge. If you have a tense relationship with another person in the house, you should share this with the Coordinator or your case manager, so that we can help you address the situation in an effective way before it escalates.
10. **Confidentiality:** We will protect your privacy by not disclosing or sharing intimate aspects of your case with anyone outside our program. We ask you to avoid sharing information about staff or residents with volunteers, other clients or Catholic Charities staff who do not work directly in the Residential Programs.
11. **Same house, but not same path.** Each resident has her own plan of care, priorities and responsibilities. Even though everybody has the same rights, they won't necessarily have the same responsibilities and plans. For your benefit and the benefit of the program, show support to other residents in their journey and abstain from comparing yourself with others. This will cause unnecessary tension in your relationships and will not benefit your stay in the program. But if you feel that you are not treated fairly, you have the right to fill a confidential Grievance form and slide it under the Director's office door (Heidi Hernandez).



## Madonna House – Main recommendations

1. We have an honor system, based on trust and respect. If you decide to lie about plans and do not want to share important information, remember that you are the only one standing in the way of your success. We have no reason to not believe you or not to trust you, until the trust is broken.
2. Please respect the standards of Christian living as set forth by the Catholic Church, including the practice of self-control and chastity, during your stay at Madonna House. Pregnancy and the post-partum period are often stressful. Your time at Madonna House is a time to work on yourself and organize your life for you and your baby. Dating is not recommended.
3. Occasionally, there will be some optional activities for recreation. You have the freedom to participate in them. We encourage you to at least try them (going to the movies, a show, to the zoo with other residents). These activities promote a sense of community and sisterhood.
4. After the 30 days orientation, we expect you to adhere by the rules and policies of the house. These rules serve as a path to create an effective routine and structure that will benefit you when you go back to independent living. The rules were made to help you and help other residents to live with harmony and success. There is a reason and a learning goal behind each rule. Trust us!
5. The Care Assistant is your resource for daily life in Madonna House. Your Case Manager is a support to help you navigate and achieve the goals and objectives that you decide for yourself and determine in your Plan of Care. In the event of emotional conflict or changes in your identified goals/objectives, your case manager will be there to support you, problem solve and/or advocate on your behalf to the appropriate people. The program Coordinator determines programming, schedules events and volunteers, and directs the overall functioning of Madonna House.
6. On occasion you will interact with other Catholic Charities staff and volunteers related to other programs. We expect you to be friendly with them and develop new support systems with them. But remember that privacy and confidentiality on your behalf and other residents' behalf also applies to them.
7. You can buy the supplies you need for you baby, as well as bus passes, by earning Madonna Dollars. We encourage you to be proactive and not wait until the last minute to get all the points to get something you need.
8. At Madonna House, we want to help you gain skills to be successful in independent living, and like such, we will treat you as an independent woman. We are not here to solve your problems, but to empower you to solve them. We will be happy to support you, but remember that this challenge is yours.

## The Mission of Catholic Charities

The mission of Catholic Charities is to be Christ's merciful love to those who suffer.

### Our Values

**Faith.** Trusting in God to order our path daily and through His grace to lead us to eternal life in His loving presence.

**Hope.** We now see glimpses of our Creator in the Church, Her Sacraments, and the love of His people; our ultimate Hope is in His promise that we will dwell with Him for eternity.

**Charity.** A love that comes directly from God and is shared with the world through His people; this love is selfless, sacrificial, and unconditional.

**Dignity.** Endowed with a spiritual soul, with intellect and with free will, the human person is from his very conception, offered to God and destined for eternal beatitude.

**Solidarity.** Equal in God's creation and united in the love of Christ, every person is our brother or sister – this solidarity must be lived through us daily as we “bear one another's burdens.”

I understand that as a resident of Transitional Living, I am expected to respect and practice the Mission and Values of Catholic Charities.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



P.O. Box 580460 | Tulsa, OK 74158-0460  
918.949.HOPE (4673) | cceok.org

## Consent for Care and Treatment

I, \_\_\_\_\_, consent to care and treatment at Catholic Charities Counseling Services, including assessment, evaluation, and therapeutic counseling as may be deemed necessary or advisable. I understand that my treatment with Catholic Charities is voluntary. I understand I have the right to accept or refuse recommended treatment and/or procedures.

### Release of Information

All records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations.

Information (including the fact that the person is a client here) will not be released to another person without explicit written permission and consent, except for the special circumstances listed below:

- Professionals at this agency may discuss cases among themselves for consultation in planning the most effective course of treatment.
- Parents or guardians of minors have a right to have the counselor’s general impression of the child’s difficulties and progress; however, the counselor reserves the right to keep specific details of the child’s counseling confidential.
- If there are legal actions involved, records may be released and/or counselor’s testimony requested if a court order is obtained.
- There are two situations in which professionals are required by law to disregard confidentiality:
  1. If the client reveals information indicating a clear and imminent danger to harm self or other, the professional will contact the appropriate authorities, family members and/or the threatened person.
  2. All helping professionals are required by law to report any knowledge or suspicion of abuse of a child or an aged, disabled or incompetent person.

### Financial Responsibilities

I understand that I am responsible for any amount due in consideration of counseling services rendered. All amounts estimated or known to be payable by me become due at the time of service (including, but not limited to, my agreed upon *per visit fee* and previous balance, if any).

### Certification

I certify that I have read each of the above statement. I have had each item explained to me to my satisfaction and that I am the client or am duly authorized by the client to sign this agreement and accept its terms.

_____	_____	_____
Client, Guardian, or Authorized Person	Date	Relationship
_____	_____	_____
Witness	Date	Relationship



P.O. Box 580460 | Tulsa, OK 74158-0460  
918.949.HOPE (4673) | cceok.org

## DRUG TEST CONSENT and RESULTS FORM

I, \_\_\_\_\_, do consent to be screened for drugs by Madonna House/St. Elizabeth Lodge Staff or approved volunteer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Test: \_\_\_\_\_

Positive Results For: (Check box for each positive result):

- |   |   |
|---|---|
| <input type="checkbox"/> AMP: Amphetamine     | <input type="checkbox"/> MTD: Methadone                 |
| <input type="checkbox"/> BAR: Barbiturates    | <input type="checkbox"/> MET: Methamphetamine           |
| <input type="checkbox"/> BZO: Benzodiazepines | <input type="checkbox"/> OPI: Opiates 2000 ng/ml        |
| <input type="checkbox"/> BUP: Buprenorphine   | <input type="checkbox"/> OPI: Opiates 300 ng/ml         |
| <input type="checkbox"/> COC: Cocaine         | <input type="checkbox"/> OXY: Oxycodone                 |
| <input type="checkbox"/> MDMA: Ecstasy        | <input type="checkbox"/> PCP: Phencyclidine             |
| <input type="checkbox"/> THC: Marijuana       | <input type="checkbox"/> TCA: Tricyclic Antidepressants |

Comments:

---

---

I ACKNOWLEDGE THE RESULTS OF MY DRUG SCREENING by SIGNING BELOW:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_

**AmericanChecked, Inc.**

**Investigative / Consumer Report Disclosure & Release**

In connection with my employment/volunteerism or application for employment (including contract for services and volunteer work), an investigative consumer report and consumer reports, which may contain public record information, may be requested from AMERICANCHECKED, INC. These reports may include the following types of information: names and dates of previous employers, reason for termination of employment, work experience, accidents, academic history, professional credentials, drugs/alcohol use, information relating to your character, general reputation, personal characteristics, mode of living, educational background, or any other information about you which may reflect upon your potential for employment gathered from any individual, organization, entity, agency, or other source which may have knowledge concerning any such items of information. Such reports may contain public record information concerning your driving record, workers' compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies which maintain such records.

I authorize AMERICANCHECKED, INC. to prepare a consumer report or investigative consumer report about me for employment/volunteer-related purposes. I have been provided a copy of the summary of the rights of the consumer pursuant to the Fair Credit Reporting Act (FCRA).

I hereby fully release and discharge AMERICANCHECKED, INC., their respective affiliates, subsidiaries, directors, officers, employees, agents and attorneys thereof, and each of them, and any individual, organization, entity, agency, or other source providing information to AMERICANCHECKED, INC. from all claims and damages arising out of or relating to any investigation of my background for employment/ volunteer purposes. This release is valid for all federal, state, county and local agencies, authorities, previous employers, military services and educational institutions.

AMERICANCHECKED, INC. is authorized to disclose all information obtained to the requesting entity for the purpose of making a determination as to my eligibility for employment/volunteerism, promotion or any other lawful purpose. I agree that such information, and my employment history, may be supplied to AMERICANCHECKED, INC. If hired or contracted, this authorization shall remain on file and shall serve as ongoing authorization for the procurement of consumer reports at any time during my employment/volunteerism or contract period.

By signing below, I certify that I have read and fully understand this release, that prior to signing I was given an opportunity to ask questions and to have those questions answered to my satisfaction, and that I executed this release voluntarily and with the knowledge that the information being released could affect my being hired, my employment/volunteerism, or my eligibility for promotion.

Today's Date \_\_\_\_\_ Signature \_\_\_\_\_

Print your full name \_\_\_\_\_

For purposes of gathering this information, I agree to supply the following information, which may be required by law enforcement agencies and other entities for positive identification purposes when checking records. It is confidential and will not be used for any other purpose.

Print other last names you have used \_\_\_\_\_

List States and Counties of Residence for the past:  3 years  5 years  7 years  10 years  
(Attach a separate sheet if more space is needed.)

State \_\_\_\_\_ City/County \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

State \_\_\_\_\_ City/County \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

State \_\_\_\_\_ City/County \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

State \_\_\_\_\_ City/County \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Driver's License No. \_\_\_\_\_ State Issuing License \_\_\_\_\_

Sex: Male Female Race: Asian Black Hispanic White Other \_\_\_\_\_  
(circle one) (circle one)

You have the right to receive, upon your written request within a reasonable period of time, (not to exceed 30 days) a complete and accurate disclosure of the nature and scope of the investigation requested. You have the right to make a request to AMERICANCHECKED, INC., upon proper identification, to request the nature and substance of all information in its files on you at the time of your request, including the sources of information, and the recipients of any reports on you that AMERICANCHECKED, INC. has previously furnished within the two-year period preceding your request. AMERICANCHECKED, INC. may be contacted by mail at 4870 S. Lewis Ave. Ste. 211, Tulsa, Oklahoma, 74105, or by phone at (800) 975-9876.

(Oklahoma, Minnesota, or California residents requesting a copy of their credit report will receive a copy of the report pulled directly from Trans Union LLC)

- Oklahoma Applicants Only: I request a copy of any *credit* report requested on me.
- Minnesota Applicants Only: I request a copy of any consumer report requested on me.

**Notice to California Applicants**

Under California law, the consumer reports we order on you for employment purposes within the State of California are defined as investigative consumer reports. These reports may contain information on your character, general reputation, personal characteristics and mode of living. Under section 1786.22 of the California Civil Code, you may view the file maintained on you by AMERICANCHECKED, INC. during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at AMERICANCHECKED, INC. in person, by mail, or by telephone. AMERICANCHECKED, INC. may be contacted by mail at 4870 S. Lewis St Ste. 211 Tulsa, Oklahoma, 74105, or by phone at (800) 975-9876. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

I request to receive a free copy of any investigative consumer report ordered on me by checking this box.

(California applicants only)

Please complete the following:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Company Name: \_\_\_\_\_ Location No.: \_\_\_\_\_