****

**Thank you for applying to the YWCA Helena WINGS Program**

The first 4 pages that come before the application ***are for you to keep*** and will help you learn more about the YWCA WINGS Program and guide you through what is needed to fully complete your application.

**Steps to apply:**

1. Please fill out each page of the YWCA WINGS Program Application completely to the best of your knowledge.
2. Remember to list three people on the reference page that you feel would be able to provide helpful information about how our program can best support you (for example: your Addiction Counselor, Mental Health Provider, Probation Officer, Social Worker, Medical Prover, etc.).
3. Please complete a separate Release of Information Form (last page) for each treatment center or provider and any other professionals you are involved with such as Adult Probation and Parole, MAT Provider, etc.
4. Include with the application your most recent Biopsychosocial Assessment – also known as a Substance Use and Dependency Evaluation or a Chemical Dependency Evaluation, also helpful to include with the application is your most recent Mental Health Assessment.
5. Submit your application in person to the YWCA at 501 North Park Avenue. You can also fax the application to 406-442-0428, or you can email the application to [kim@ywcahelena.org](mailto:kim@ywcahelena.org).
6. Follow up with a phone call to 406-442-8774 to check in on the status of your application, and always call to update information when necessary – especially if your contact information has changed (we want to be able to reach you)!

If at any point you have questions or need support with community resources, please reach out to us at 406-442-8774 and we will be happy to assist you.

**WINGS Program Expectations** **–** please read carefully to determine if WINGS will be the right program for you and please let us know if you have questions:

Upon move-in, all WINGS Participants are expected to sign the WINGS Program Agreement and Lease which outlines all Program Expectations and Housing expectations. Each Program and Housing Expectation is in place to help all Participants achieve the overall goal of obtaining permanent housing that she can sustain.

Primary expectations to be aware of **prior to move-in** are as follows:

* There is ZERO TOLERANCE for drug or alcohol use on the YWCA premises. There is also ZERO TOLERANCE for dishonesty about personal drug or alcohol use or aiding another WINGS Participant’s drug or alcohol use. If a participant has a lapse or relapse it is essential that the participant inform Staff immediately. This a place to find freedom and safe shelter from drug and alcohol use. HONESTY, OPENNESS and WILLINGNESS are key expectations of all Participants.
* Participants **are expected not to use alcohol or other drugs on or off** YWCA Helena premises.
  + Random urine analyses will be completed with all Participants. Daily call-ins to Community Solutions, Inc. are required. If the Participant’s name is on the random list, UA testing is mandatory on that day.
  + Random room inspections will be completed with all Participants.
* Participants will meet with her WINGS Addiction Counselor *at least* **once a week** to develop an action plan for sustainable recovery.
* Participants will meet with her WINGS Clinical Mental Health Counselor *at least* **once per week** to address co-occurring in our Integrated Co-Occurring Treatment model.
* Weekly meetings with WINGS Peer Supports are also a program expectation. Peer Supports will be a helpful part of participant’s early recovery processes and also work with individuals on case management strategies including 1) Employment/Education, 2) Permanent Housing, 3) Self-Care, 4) Community Connectivity, 5) Mental Health, and 6) Financial Budgeting as a part of this recovery plan.
* **According to the unique situation of each participant and within the first 90 days of programming**, each participant will engage with their treatment team to discuss employment readiness and opportunities. The expectation is to work up to 20 hours only to start, with a steady increase as readiness is determined by the participant and her treatment team.
* Participants are expected to seek support from community recovery groups (AA, NA, Celebrate Recovery, etc.) and seek Sponsorship support immediately through a Sponsor *outside* of the YWCA.
* Participants **attend a daily morning group from 8:30 – 9:30 am, Monday through Thursday**.
* **Participants attend trauma-sensitive and gender-specific recovery and relational groups including:** Relationship/Attachment, Women in Recovery, Seeking Safety, Beyond Trauma, Circle of Security (see next item below), and Love & Logic. Other activities may be added when designated as vital to Program completion and determined in collaboration with the participant and her treatment team.
* Because of the close association and interaction with Participant’s children in the WINGS Program, all WINGS Participant will be expected to complete the Circle of Security parenting class. WINGS Participants who have children will also be expected to sign a child addendum outlining child care expectations and to work closely with onsite parenting advocates to foster the healthiest mother/child relationship.
* Participants **must stay at YWCA Helena every night to be accountable to the program and one’s own sobriety**. Any plans that involve staying somewhere other than the YWCA overnight *must be agreed upon and arranged with your treatment team at least a week in advance.*
* Participants are to pay their housing fee on the first business day of every month while in the program.
  + Program fees are calculated as **25%** of the Participant’s annual gross income.
  + The lowest fee due is $50 and the highest amount is $250, dependent on income.
  + Participants are expected to give the Agency Coordinator (Marci) copies of all paystubs and proof of any other income so that appropriate calculations may be completed.
  + **Participants are expected to pay the full amount of the housing fee prior to move-in**
  + **A refundable key deposit of $75 is also required for each participant’s room ($25), mailbox ($25), and kitchen cabinet key ($25).**
* Upon move-in, Participants will be provided with one bin, if needed, to move in personal items. **This bin** may be put in a locked storage room in the basement of the building for added space in resident rooms, if needed.
  + A Participant that has children will be provided with one extra bin per child. These can be moved to locked storage downstairs, if needed.
  + Participants **may not** bring in extra furniture, a refrigerator, extension cords, or any other unnecessary items. Participants will discuss with their treatment team the possibility of having a television PRIOR to getting one.
* Upon move-out, Participants will remove all personal belongings from their resident room, either to an agreed upon storage space at the YWCA (can be stored for up to 30 days) or to a designated location off YWCA property. Anything left in the room will be discarded.

We look forward to receiving your completed application. Again, if you have questions or need assistance, please reach out to us at 406-442-8774. Fax number is (406) 442-0428.

**Thank you!**



**YWCA WINGS Program Application**

**Women Initiating New Growth and Stability**

MIssion Statement

The YWCA is dedicated to eliminating racism, empowering women and promoting peace, justice, freedom and dignity for all.

The YWCA of Helena is committed to providing women with safe, affordable housing and assistance in accessing community resources.

We ask a lot of questions in this application, so we can get to know the women interested in living at the YWCA and learn how we can support participants in achieving life goals.

General information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_

First Middle Last

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Physical Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it safe to call/leave a message YES NO

Other contact Name & Message Numbers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_

Who is your Emergency Contact?

Phone Number?

If accepted, where are you coming from? Circle one:

Jail Prison Prerelease Treatment Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in Helena? YES No

How long have you been in Helena? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about the YWCA?

Have you lived at the YWCA before? YES NO

If yes: When did you live at the YWCA? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why did you move out? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check** any agencies you are currently working with or have worked with in the last year:

\_\_\_AWARE

\_\_\_Boyd Andrew

\_\_\_Ctr for Mental Health

\_\_\_Pure View

\_\_\_Counseling

\_\_\_CTI

\_\_\_DPHHS/CPS

\_\_\_Family Promise

\_\_\_God’s Love

\_\_\_Good Samaritan

\_\_\_Helena Industries

\_\_\_Job Service

\_\_\_Public Defender

\_\_\_Food Share

\_\_\_Helena Indian Alliance

\_\_\_Prison/prerelease

\_\_\_Probation and Parole

\_\_\_St. Peter’s Hospital

\_\_\_Salvation Army

\_\_\_Voc-Rehab

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

personal

Have you experienced violence in any form since you turned 18? YES NO

If yes, did you get any counseling? YES NO

Do you currently feel safe? YES NO

If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you a single head of household? YES NO

Do you have a service animal? YES NO

Have you ever served in the military? YES NO

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you receiving benefits? YES NO

Enrolled Tribal member? YES NO

vehicle

Do you own your own vehicle? YES NO

Do you have auto insurance? YES NO

Do you have a driver’s license? YES NO

If no, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOUSING

Are you homeless or about to become homeless? YES NO

Where did you sleep last night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you signed up for low-income housing? YES NO

If yes, when and which agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe your current living situation (where are you living, for how long, circumstances leading up to now) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you know any of the current or recent residents of the YWCA? If so, who do you know and how do you know them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT AND INCOME**

Do you have the ability to work? YES NO  
If no, please explain: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently employed? YES NO

Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours do you work each week? \_\_\_\_\_\_\_\_\_ What is your hourly pay? \_\_\_\_\_\_\_\_\_\_

What job skills do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have other sources of income? YES NO

|  |  |  |
| --- | --- | --- |
| Other Source of Income | **🗸** | Amount You Get Monthly |
| Social Security |  |  |
| SSI |  |  |
| SSDI |  |  |
| Unemployment |  |  |
| SNAP |  |  |
| TANF |  |  |
| Child Support |  |  |
| Other: |  |  |

**Please check all that apply**

education

Mark your highest level of education, including partial completion.

|  |  |
| --- | --- |
| Highest Level of Education | **🗸** |
| Some High School (please circle the grade) 9 10 11 12 |  |
| High School Diploma |  |
| GED |  |
| Some College or Trade School, no degree |  |
| Some College and a Professional Certification |  |
| Associates Degree |  |
| Bachelors Degree |  |
| Masters Degree |  |
| PhD |  |

Are you currently enrolled in school? YES NO

If yes, what school do you attend? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you plan on enrolling in school? YES NO

Family Size and income

Please list **yourself** **and all your children whether or not they have been living with you** Please mark if your children are living with you in the appropriate box. Disregard income for those children who are not currently living with you. For monthly income, indicate the gross amount received (gross income refers to the pre-tax amount; include salary, tips, and state assistant.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Family  Relationship – Son or Daughter | Name (First, Middle, Last) | Birthday mm/dd/yy  Social Security Number | Living with  You or potential for living with you  (Yes or No) | Monthly  Income From  All Sources |
| You |  |  |  |  |
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If your child(ren) is school-aged, what school do they attend? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the custody and living arrangements (parenting plan, visitation, etc):  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is CPS/DPHHS involved? YES NO

If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case worker name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attorney name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will your child(ren) be living with you at YWCA Helena? YES NO

Or, do you plan on reuniting with your child/ren while at YWCA Helena? YES NO

Are you currently pregnant? YES NO

If yes, how far along? \_\_\_\_\_\_\_\_\_\_

Are you currently breastfeeding? YES NO

|  |  |
| --- | --- |
| Relationship Status | **🗸** |
| Single |  |
| In a Relationship |  |
| Married |  |
| If married, to whom and for how long? | |
| Separated |  |
| Divorced |  |
| Widowed |  |

**PHYSICAL AND BEHAVIORAL HEALTH**

Do you have any physical health problems? (seizures, diabetes, etc.) YES NO  
 Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any disabilities? YES NO Receiving SSDI? YES NO

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need special accommodations? YES NO

Please explain (ambulatory devices, shower aids): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like us to know your COVID vaccination status? (This information is voluntary and NOT required for admission to the YWCA.) If so, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated for a mental illness? YES NO

If yes, was/is there a treatment plan? YES NO

Please describe treatment plan and who developed/administered the plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently working with a mental health counselor? YES NO

For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_

If not currently, have you worked with a mental health counselor previously? YES NO

legal

YWCA Helena serves women who have had legal system involvement, please be as specific as possible as this will not hinder acceptance into the WINGS program.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Charge | County, State | Date | Outcome (incarceration, probation, fines, etc) | Date Resolved |
|  |  |  |  |  |
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Additional information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any unresolved legal charges YES NO

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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Do you have legal representation? YES NO

Representing attorney \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Scheduled sentencing date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_

Are you on probation or parole? YES NO

Name of Parole/Probation Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

How long have you been on probation/parole? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you paying fines or restitution? YES NO

How many hours of community service: \_\_\_\_\_\_\_\_\_\_\_ Amount of fines/restitution: \_\_\_\_\_\_\_\_\_\_

Alcohol and Other drugs

Are you currently dependent on alcohol and/or other drugs? YES NO

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Substance | Never  used | Age of 1st use | Date of last use | Frequency of use | Typical amount | Method of use | System involved |
| *EXAMPLE: methamphetamine* |  | *14* | *6/26/22* | *3 X Day* | *1 gram* | *Snort* | *PO, Court CPS* |
| Alcohol |  |  |  |  |  |  |  |
| Tobacco |  |  |  |  |  |  |  |
| Tranquilizers |  |  |  |  |  |  |  |
| Inhalants |  |  |  |  |  |  |  |
| Marijuana |  |  |  |  |  |  |  |
| Hallucinogens (LSD, Mushrooms) |  |  |  |  |  |  |  |
| Amphetamines (Speed) |  |  |  |  |  |  |  |
| Barbiturates (Downers) |  |  |  |  |  |  |  |
| Methamphetamine |  |  |  |  |  |  |  |
| Opiates (Heroin) |  |  |  |  |  |  |  |
| Cocaine |  |  |  |  |  |  |  |
| Prescription Pain Medication |  |  |  |  |  |  |  |
| Adderall/Ritalin/Stimulants |  |  |  |  |  |  |  |
| Suboxone or Naloxone |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |

Other addictions, not alcohol or drugs: examples; work, sex, money: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience withdrawal symptoms when you stop using? YES NO  
What are your symptoms (seizures, DT’s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing withdrawal symptoms? YES NO

Have you attended **inpatient** chemical dependency treatment? YES NO

If yes, please list information about your inpatient treatment below:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Treatment facility | City, State | Entry Date | Discharge Date | Still Attending? | Did you complete? | If no, why? |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Have you attended **outpatient** **substance use disorder treatment?** YES NO

If Yes, please list the information about your **outpatient treatment:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Treatment facility or Provider | City, State | Entry Date | Discharge Date | Still Attending? | Did you complete? | If no, why? |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Have you ever experienced life difficulties or problems because of alcohol or other drugs?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone ever expressed concerns about your use of alcohol or other drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you attend AA or NA? YES NO

Are you working with an Addiction Counselor? YES NO

Or - Have you worked with an Addiction Counselor in the past? YES NO  
If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Future Plans**

Are your family members supportive of your sobriety at this time? YES NO

If yes, how are they supportive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why do you want to come to YWCA Helena? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Why are you seeking treatment at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark the number that best describes your readiness to change your life:

1 being I do not want to change and 5 being I will do whatever it takes

1 2 3 4 5

Do you have a long-term sobriety plan? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

\_\_\_ Signed up for IOP/OP

\_\_\_ Created a plan with Probation Officer

\_\_\_ Started GED

\_\_\_ Searching for employment

\_\_\_ Signed up for SNAP, Medicaid, etc

\_\_\_ AA or NA groups

\_\_\_ Working with or signed up with an Addiction Counselor

\_\_\_ Working with or signed up with a mental health counselor

\_\_\_ Applied for housing

**STATISTICAL INFORMATION**

|  |  |
| --- | --- |
| Racial Identification | **🗸** |
| American Indian/Alaskan Native |  |
| Asian |  |
| Black/African American |  |
| Hispanic |  |
| Native Hawaiian/Other Pacific Islander |  |
| White |  |
| American Indian/Alaskan Native & White |  |
| Asian & White |  |
| Black/African American & White |  |
| American Indian/Alaskan Native & Black/African American |  |
| Other Multi-Racial |  |
| Preferred Not to Answer |  |

Please make a checkmark in the appropriate box. In some cases, you may need to place a checkmark in more than box. Public use of this information will not be connected to individuals and is YWCA Helena population statistics only.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Where did you sleep last night? | | | | | | | | | | **🗸** |
| Non-housing (street, park, car, etc.) | | | | | | | | | |  |
| Emergency shelter | | | | | | | | | |  |
| Transitional housing | | | | | | | | | |  |
| Psychiatric facility\* | | | | | | | | | |  |
| Substance abuse treatment facility\* | | | | | | | | | |  |
| Hospital\* | | | | | | | | | |  |
| Jail/prison\* | | | | | | | | | |  |
| Domestic violence situation | | | | | | | | | |  |
| Living with relatives/friends | | | | | | | | | |  |
| Rental housing | | | | | | | | | |  |
| Other (please specify) | | | | | | | | | |  |
| Could be kicked out of where you are staying in next 14 days without a place to go? | | | | | | | | | |  |
| Housing History | | | | | | | | | |  |
| Have you been without a home 4 or more times in the last 3 years? | | | | | | | | | |  |
| Your Age Range | | | | | | | | | |  |
| 17 yrs. and under | |  | 18-30 yrs |  | 31-50 yrs |  | 51-61yrs |  | Over age 62 |  |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
|  |
|  | | | | | | | | | | |

**Adverse Childhood Experiences (ACE’s) Score Questionnaire**

Many stressful life experiences are listed in the table below. Please answer the questions for yourself if you are our client, or for your child if you are completing this questionnaire as a parent or guardian.

In the left-hand column, answer “Yes” if you’ve had the experience or “No” if you have not.

Then in the two columns on the right, rate how much the experience bothered you when it happened, and how much it bothers you now, using the 0-10 scale from “Not at All” to “Very Much”.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Have You Had This Experience?** |  | **Description of Life Experience** | **How Much Did This Experience Bother You At The Time It Happened?** |  | **How Much Does This Experience Bother You Now?** |
| **Enter**  **Yes or No** |  | **While I was growing up, during my first 18 years of life…** | **0 – Not at all**  **to**  **10 – Very Much** |  | **0 – Not at all**  **to**  **10 – Very Much** |
|  | 1 | A parent or other adult in my home **often or very often**… swore at me, insulted me, put me down, or humiliated me. Or – acted in a way that made me afraid that I might be physically hurt. |  |  |  |
|  | 2 | A parent or other adult in my home **often or very often**… pushed, grabbed, slapped, spanked, choked, or threw something at me. Or – **ever**, even just once, hit me so hard that I had marks or I was injured. |  |  |  |
|  | 3 | An adult or person at least 5 years older than me **ever**, even just once… touched or fondled me or had me touch their body in a sexual way. Or – attempted or actually had oral, anal, or vaginal intercourse with me. |  |  |  |
|  | 4 | I **often or very often**… felt that no one in my family loved me or no one in my family thought I was important or special. Or – my family members didn’t look out for each other, feel close to each other or support each other. |  |  |  |
|  | 5 | I **often or very often** felt that… I did not have enough to eat, had to wear dirty clothes, and had no one to protect me. Or my parents were too drunk or high to take care of me or take me to the doctor if I needed it. |  |  |  |
|  | 6 | My parents were **ever** separated or divorced, even if they got back together. |  |  |  |
|  | 7 | My mother or stepmother **often or very often** was pushed, grabbed, slapped or had something thrown at her. Or **sometimes, often or very often** was kicked, bitten, hit with a fist, or hit with something hard. Or **ever** was repeatedly hit at least a few minutes or threatened with a gun or knife. |  |  |  |
|  | 8 | I lived with someone who was a problem drinker or alcoholic or used street drugs. |  |  |  |
|  | 9 | A parent or other adult in my home was depressed, or was mentally ill, or attempted suicide. |  |  |  |
|  | 10 | A parent or other adult in my home went to prison. |  |  |  |

Your Name: Date:

http://acestoohigh.com/got‐your‐ace‐score/ 2

RESILIENCE Questionnaire

Please circle the most accurate answer under each statement:

I believe that my mother loved me when I was little.

Definitely true Probably true Not sure Probably Not True Definitely Not True

I believe that my father loved me when I was little.

Definitely true Probably true Not sure Probably Not True Definitely Not True

When I was little, other people helped my mother and father take care of me and they seemed to love me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

I’ve heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.

Definitely true Probably true Not sure Probably Not True Definitely Not True

When I was a child, there were relatives in my family who made me feel better if I was sad or worried.

Definitely true Probably true Not sure Probably Not True Definitely Not True

When I was a child, neighbors or my friends’ parents seemed to like me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

When I was a child, teachers, coaches, youth leaders or ministers were there to help me.

Definitely true Probably true Not sure Probably Not True Definitely Not True

Someone in my family cared about how I was doing in school.

Definitely true Probably true Not sure Probably Not True Definitely Not True

My family, neighbors and friends talked often about making our lives better.

Definitely true Probably true Not sure Probably Not True Definitely Not True

We had rules in our house and were expected to keep them.

Definitely true Probably true Not sure Probably Not True Definitely Not True

When I felt really bad, I could almost always find someone I trusted to talk to.

Definitely true Probably true Not sure Probably Not True Definitely Not True

As a youth, people noticed that I was capable and could get things done.

Definitely true Probably true Not sure Probably Not True Definitely Not True

I was independent and a go-getter.

Definitely true Probably true Not sure Probably Not True Definitely Not True

I believed that life is what you make it.

Definitely true Probably true Not sure Probably Not True Definitely Not True

How many of these 14 protective factors did I have as a child and youth? (How many of the 14 were circled “Definitely True” or “Probably True”?) \_\_\_\_\_\_\_ Of these circled, how many are still true for me? \_\_\_\_\_\_\_

Head Trauma History

Please put “Yes” or “No”

H = Hit on head

Have you ever:

\_\_\_\_ Been hit in the face or head? With what?

\_\_\_\_ Has your head been slammed into a wall or another object?

\_\_\_\_ Been pushed so that you fell and hit your head?

\_\_\_\_ Has anyone ever shaken you?

\_\_\_\_ Have you ever been strangled or choked, or had anything else that made it hard for you to breathe?

\_\_\_\_ Have you ever had an injury to your face, head or throat in any other way?

\_\_\_\_ Have you ever been in a car accident?

If yes:

\_\_\_\_ Has anything happened more than once?

E = Emergency room treatment

\_\_\_\_ Did you ever go to the emergency room after hitting your head? Why?

If yes:

\_\_\_\_ Did they ask whether you had been hit on the head or say that they suspected that you had a head injury or concussion?

\_\_\_\_ Did you think you got all the treatment you needed?

If no:

\_\_\_\_ Was there ever a time when you thought you should go to the ER after an injury to your head, but didn’t go?

L = Loss of consciousness

\_\_\_\_ Have you ever lost consciousness or black out as result of a hit to the head or being choked?

P = Problems

\_\_\_\_ Have you been having trouble concentrating or remembering things?

\_\_\_\_ Are you having trouble finishing things you start to do?

\_\_\_\_ Have people told you that you’re not acting like yourself?

\_\_\_\_ Have you been having trouble doing what you need to do at work, school, or home?

\_\_\_\_ Are you having mood swings that you don’t understand?

\_\_\_\_ Has it gotten harder for you to function when you’re under stress?

S = Sickness

\_\_\_\_ Have you had any physical problems since your partner assaulted you? What kind?

\_\_\_\_ Do you have any recurring headaches or fatigue?

\_\_\_\_ Have you had any changes in your vision, hearing, or sense of smell or taste?

\_\_\_\_ Do you find yourself dizzy or experiencing a lack of balance?

References

Please provide three (3) references. Some examples of references include employers, case managers, counselors, landlords, co-workers, and teachers.

Name: Phone

Address: City and State

How does this person know you? How long?

Name: Phone

Address: City and State

How does this person know you? How long?

Name: Phone

Address: City and State

How does this person know you? How long?

**Applicant Statement**

My signature below certifies that all information on this application is true, correct, and complete to the best of my knowledge, and contains no willful falsifications or misrepresentations. I authorize the YWCA to contact my present and past employers and the references listed above to obtain information deemed appropriate to consider my application for the WINGS program

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Applicant Signature Date

fair housing logo

Thank you for taking the time to fill out this application

The next page contains an Authorization for Release, Disclosure and Exchange of Health Information. Please copy and sign one for each current agency or former provider of social services, or physical, mental health or substance use treatment that you are working with. Thank you

****

**YWCA Helena**

**Authorization for Release, Disclosure, and Exchange of Health Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby authorize the disclosure of information from

Participant’s Name Birthdate

My health record.

I authorize YWCA Helena to obtain information FROM the following agency or individual:

I authorize YWCA Helena to send information TO the following agency or individual:

Name of Agency/Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information to be disclosed from my health record:

Medical Records  Discharge Summaries  Substance Use Treatment Reports

Clinical Mental Health & Substance Use Disorder Assessments  Treatment Plans

Medication Records  Insurance, Billing, and Claim Records  Routine Clinical Assessments

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Specify)

By signing this authorization, I understand that:

* I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment at YWCA Helena
* That my alcohol and drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patient records 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR parts 160 amd164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Persons receiving information may not further disclose such information if the information concerns drug or alcohol use or treatment. However, I also understand that persons receiving other types of confidential information may have the ability to disclose. I have the right to revoke this information at any time in writing, except to the extent that YWCA Helena has already provided the information.
* I may revoke this Authorization in writing at any time, except to the extent this Authorization has already been acted upon prior to the effective date of revocation. A written revocation of this Authorization must be submitted to the Executive Director of YWCA Helena at 501 N. Park, Helena, MT 59601, or email [jenifer@ywcahelena.org](mailto:jenifer@ywcahelena.org) and that revocation will only be effective upon receipt.
* If the specific record information that is the subject of the Authorization contains information related to HIV infection, AIDS or AIDS related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, the disclosure I am hereby authorizing will include that information.
* This authorization will expire 12 months from the date below unless I revoke authorization prior to that time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Printed Name Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Representative Printed Name Authorized Representative Signature Date

**Revocation Section**

I no longer want my information shared.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date