LIVE-IN PROGRAM APPLICATION

This application form must be filled out and signed by the applicant only. if you do not know the answer, please put "n/a" (not applicable). If you require assistance, please don't hesitate to call our main office line.

YOUR FULL NAME

First Name | Middle Name | Last Name

CURRENT ADDRESS

Street Address

City | State / Province

Postal / Zip Code

CONTACT PHONE NUMBER

Please enter a valid phone number.

EMAIL ADDRESS

example@example.com

GENDER

- ○ MALE
- ○ FEMALE
- ○ NON BINARY

SELECT CENTRE YOU WOULD LIKE TO APPLY TO

- [ ] WINNIPEG MENS
- [ ] THUNDER BAY MENS
- [ ] THUNDER BAY WOMANS
- [ ] BRANDON WOMANS

DATE OF BIRTH

Year Month Day

SOCIAL INSURANCE NUMBER

Please enter a valid SIN #

HOW DID YOU HEAR ABOUT ATCCC? PLEASE GIVE NAME OF INDIVIDUALS, AGENCIES OR GROUPS:

EMERGENCY CONTACT

First Name Last Name

EMERGENCY CONTACT PHONE NUMBER

Please enter a valid phone number.

THEIR RELATIONSHIP TO YOU:

MARITAL STATUS

- ○ SINGLE
- ○ MARRIED
- ○ COMMON-LAW
- ○ SEPERATED
- ○ DIVORCED

NAME OF SPOUSE

First Name Last Name

SPOUSE PHONE NUMBER

Please enter a valid phone number.

DOES YOUR SPOUSE SUPPORT YOU COMING INTO THE PROGRAM?

- ○ YES
- ○ NO

WHAT IS THE GENERAL CONDITION OF YOUR HEALTH?

DO YOU HAVE A HEALTH CARD OR HEALTH INSURANCE?

- ○ YES
- ○ NO

PLEASE INPUT YOUR HEALTH CARD NUMBER

HAVE YOU EVER BEEN TREATED FOR AIDS?

- ○ YES
- ○ NO

HAVE YOU RECENTLY TESTED POSITIVE FOR ANY COMMUNICABLE DISEASES?

- ○ YES
- ○ NO

ARE YOU SEEING A MEDICAL DOCTOR FOR ANY REASON?

- ○ YES
- ○ NO

PLEASE GIVE A REASON FOR SEEING A MEDICAL DOCTOR:

NAME OF PHYSICIAN

First Name Last Name

PHYSICIAN'S OFFICE ADDRESS

Street Address

City

State / Province

Canada

Postal / Zip Code

Country

PHYSICIAN'S CONTACT PHONE NUMBER

Please enter a valid phone number.

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS?

- YES
- NO

PLEASE GIVE US MORE DETAILS:

HOW LONG HAVE YOU BEEN TAKING MEDICATION FOR? HOW DO YOU PLAN TO PAY FOR YOUR MEDICATION WHILE YOU ARE IN OUR PROGRAM? WHY DO YOU TAKE THIS MEDICATION?

DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT WOULD HINDER YOU FROM DOING NORMAL MANUAL LABOUR?

- YES
- NO

PLEASE GIVE US MORE DETAILS:

DO YOU REQUIRE A DOCTOR PRESCRIBED DIET?

- ○ YES
- ○ NO

DO YOU HAVE ANY ALLERGIES?

- ○ YES
- ○ NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE HIGH BLOOD PRESSURE?

- ○ YES
- ○ NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE CANCER?

- ○ YES
- ○ NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE ASTHMA?

- ○ YES
- ○ NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE DIABETES?

- ○ YES
- ○ NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE ANY HEART PROBLEMS?

- ○ YES
- ○ NO

PLEASE GIVE US MORE DETAILS:

DO YOU HAVE EPILEPSY?

- ○ YES
- ○ NO

PLEASE GIVE US MORE DETAILS:

HAVE YOU EVER, OR ARE YOU NOW RECEIVING PSYCHIATRIC TREATMENT?

- ○ YES
- ○ NO

PLEASE GIVE US MORE DETAILS:

HAVE YOU EVER BEEN CONVICTED OF ANY CRIMES?

- ○ YES
- ○ NO

PLEASE GIVE US MORE DETAILS:

ARE YOU CURRENTLY IN JAIL?

- ○ YES
- ○ NO

PLEASE GIVE US MORE DETAILS ABOUT RELEASE DATE AND THE NAME OF INSTITUTION:

ARE YOU ON PROBATION OR PAROLE?

- ○ YES
- ○ NO

PROBATION/PAROLE OFFICER'S NAME

First Name Last Name

PROBATION/PAROLE OFFICER'S PHONE NUMBER

Please enter a valid phone number.

PROBATION/PAROLE OFFICE ADDRESS

Street Address

City | State / Province

Postal / Zip Code

PLEASE GIVE US DETAILS ABOUT REPORTING METHODS:

LAWYERS NAME

First Name | Last Name

LAWYERS PHONE NUMBER

Please enter a valid phone number.

LAWYERS OFFICE ADDRESS

Street Address

City | State / Province

Postal / Zip Code | Country

Canada

DO YOU HAVE ANY UPCOMING COURT APPEARANCES?

- ○ YES
- ○ NO

NEXT UPCOMING COURT APPEARANCE

Year Month Day Hour Minutes

ARE YOU AWARE OF ANY WARRANTS FOR YOUR ARREST IN ANY PROVINCE OF CANADA?

- ○ YES
- ○ NO

ARE YOU ON A DISABILITY PENSION OR OTHER PENSION CURRENTLY?

- ○ YES
- ○ NO

PLEASE GIVE DETAILS:

HOW MUCH MONEY DO YOU COLLECT? HOW OFTEN DO YOU COLLECT?

DO YOU HAVE OUTSTANDING DEBTS OR FINES?

- ○ YES
- ○ NO

PLEASE GIVE DETAILS:

HOW DO YOU PLAN TO PAY THIS OFF?

ARE THERE ANY OTHER FINANCIAL MATTERS WE SHOULD BE MADE AWARE OF?

YES

NO

PLEASE GIVE DETAILS:

ARE YOU SELLING A HOUSE, CAR OR ANY INVOLVED WITH ANY CIVIL LEGAL ACTIONS REGARDING CLAIMS?

DO YOU UNDERSTAND THAT ATCCC IS A CHRISTIAN DISCIPLESHIP PROGRAM AND THAT THERE ARE NO ALTERNATIVE RECOVERY TRACKS WITHIN OUR LONG TERM LIVE-IN PROGRAM?

YES

NO

WHY DO YOU WISH TO ENTER INTO THIS PROGRAM?

WHAT IS YOUR RELIGIOUS PREFERENCE OR DENOMINATION?

HAVE YOU EVER BEEN TO ANOTHER ATCCC LIVE-IN PROGRAM BEFORE?

- ○ YES
- ○ NO

PLEASE STATE WHICH ATCCC PROGRAM AND HOW LONG YOU RESIDED THERE?

DO YOU FLUENTLY READ, WRITE AND SPEAK ENGLISH?

- ○ YES
- ○ NO

PLEASE EXPLAIN:

STATE LAST GRADE/POST SECONDARY SCHOOL/TRAINING COMPLETED

HAVE YOU READ THE PROGRAM MANUAL IN ITS ENTIRETY?

- ○ YES
- ○ NO

DO YOU UNDERSTAND THAT THE PROGRAM IS TWELVE (12) MONTHS MINIMUM?

- ○ YES
- ○ NO

ARE YOU WILLING TO OBEY THE RULES IN THEIR ENTIRETY?

- ○ YES
- ○ NO

PLEASE COMMENT ON HOW YOU FEEL ABOUT OUR RULES:

DO YOU SMOKE?

- ○ YES
- ○ NO

DO YOU UNDERSTAND THAT OUR APPROACH IS COLD TURKEY?

- ○ YES
- ○ NO

DO YOU CONSIDER YOURSELF TO BE AN ADDICT?

- ○ YES
- ○ NO

WHAT IS IT THAT YOU STRUGGLE WITH SPECIFICALLY?

By signing below, you declare that all information on this application form is accurate to the best of your knowledge. Any misleading information may jeopardize the application process.

Signature

Date

Month Day Year