Good Shepherd Recovery House
601 Moore Rd.
Jasper Ga. 30143
Phone 678-459-2346
Fax 888-826-6972

RESIDENT APPLICATION CHECKLIST:

1) Review, sign and initial **every page** of this application where applicable. Send back **every page**.
2) Make sure to sign the Background Check Authorization form – it is the first thing we must submit before proceeding with intake. You may not have any sexual charges or violent felony battery charges, or more than one (1) misdemeanor battery charge.
3) Submit a 3 – 5 page letter telling us about yourself, your history, and why you want to come to Good Shepherd Recovery House.
4) You must be interviewed by the Executive Director and/or Program Director in person, or by phone or video.
5) Submit a copy of your Driver's License or other Photo ID as proof of identification
6) Proof of COVID vaccination and/or COVID rapid results.
7) $35 Intake Fee for Background Check
8) $500 Intake Fee
9) $1000 1st Month Program Fees
10) $100 for Medical Testing upon Intake, which includes a Nurse Exam, TB and RPR (Syphilis) Test (required by the State), as well as testing for HIV, Hep A B C.
Testing is solely to ensure that anyone with a transmittable disease receives the medical treatment and medications they require, and if necessary, they will be quarantined in the house until they are no longer contagious. No one may go into the kitchen until these tests results have been returned.

If you have any questions, please feel free to call the Executive Director at 678-459-2347 or the Program Director at 678-459-2437, or email info@gsrecovery.org.

You can scan and email ALL PAGES of the documents to info@gsrecovery.org, or fax them to 888-826-6972.

Written Disclosure, Consent, and Authorization

HORIZON

I understand that **Good Shepherd Recovery House** will utilize the services of Horizon Background Screening, 12460 Crabapple Rd, Suite 202-271, Alpharetta, GA 30004-6386 (the "Agency), to obtain a consumer report and/or investigative consumer report ("Report") as part of its review of my application for service as an employee, volunteer, or other association. I also understand that if accepted, to the extent permitted by law, the organization may obtain further Reports throughout my employment or volunteer service from a consumer reporting agency.

I understand the Agency's investigation may include obtaining information regarding my credit background, bankruptcies, lawsuits, judgments, paid tax liens, unlawful detainer actions, failure to pay spousal or child support, accounts placed for collection, character, general reputation, personal characteristics and standard of living, driving record and criminal record, subject to any limitations imposed by applicable federal and state law. I understand such information may be obtained through direct or indirect contact with former employers, schools, financial institutions, landlords and public agencies or other persons who may have such knowledge. If an investigative consumer report is being requested, I understand such information may be obtained through any means, including but not limited to personal interviews with my acquaintances and/or associates or with others whom I am acquainted.

I acknowledge receipt of the attached summary of my rights under the Fair Credit Reporting Act and, as required by law, any related state summary of rights (collectively "Summaries of Rights").

This consent will not affect my ability to question or dispute the accuracy of any information contained in a Report. I understand if the Employer makes a conditional decision to disqualify me based all or in part on my Report, I will be provided with a copy of the Report and another copy of the Summaries of Rights, and if I disagree with the accuracy of the purported disqualifying information in the Report, I must notify the Employer within five business days of my receipt of the Report that I am challenging the accuracy of such information with the Employer.

I hereby consent to this investigation and authorize the Company to procure a consumer report and investigative consumer report on my background as stated above from a consumer reporting agency and/or investigative consumer reporting agency.

Applicant Signature_____ **Today's Date** _____/_____/_____

Please write clearly in Black Ink only – Email to requests@horizonscreening.com

Name (Last)_____(First)_____ (Middle)_____

List any other name used in the last 7 years_____

Date of birth _____/_____/_____ Social Security Number _____-_____-_____

Drivers License # _____ State _____ Phone # (Day) (_____)_____-_____

Professional License Held _____State_____Lic.#_____

List your current mailing address as well as any other cities or towns you have lived in the past 7 years:

Street or PO#_____City_____ State_____ Zip _____

City _____ State_____ Zip _____Dates ___/___to___/___

City _____ State_____ Zip _____Dates ___/___to___/___

******APPLICANT – DO NOT WRITE BELOW THIS LINE******

Company Name: ____Good Shepherd Recovery House___ Contact: _____

These forms are provided to our clients as a courtesy, and all clients are encouraged to have all forms reviewed by legal counsel to ensure the use of compliant authorization forms. Horizon Background Screening bears no responsibility with regard to the use or non-use of these forms.

While the information contained in the reports we will provide have been obtained from public records data sources deemed reliable, its accuracy cannot be guaranteed due to potential human error in the actual recording of the record. Since this information is not owned by Horizon Background Screening and since public records data on any one individual, group of individuals, company, or companies can be contained in more than one repository Horizon Background Screening can only rely on its accuracy from the public records data sources presently available at the time of the search. This information is furnished for your exclusive use and accepted by you without any liability on the part of Horizon Background Screening its sources, officers, agents or employees. Furthermore you agree to indemnify Horizon Background Screening, its sources, agents, and employees of any liability for the use of this information and shall agree that the right to obtain and the purpose for this information, for your exclusive use, is fully within the appropriate law or laws which apply to the permissible purpose of retrieving background information on an individuals criminal records history, credit history and / or workers compensation claim history.

RPM Ministries, Inc is the ministry that Good Shepherd Recovery House (GSRH) is operating under. All information, rules and guidelines set forth in these documents are to be applied to and adhered to by Good Shepherd Recovery House, and any other ministry that may operate under the covering of RPM Ministries, Inc.

Intake Application

NAME: _____ DATE: _____

RECENT ADDRESS: _____

DEMOGRAPHICS (optional – Circle One): American Indian, Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or White.

DATE OF BIRTH: _____ PLACE OF BIRTH: _____ SS #: _____

HOME PHONE#:_____ CELL #: _____ WORK # _____

EMAIL ADDRESS:_____

NAME OF SPONSOR: (Family) _____SPONSORS PH#:_____

ADDRESS OF SPONSOR: _____

RELATIONSHIP INFORMATION:
MARRIED / SINGLE / DIVORCED: ____ SPOUSE/EX-SPOUSE'S NAME: _____

HOW MANY YEARS MARRIED? _____ # OF CHILDREN: _____

CHILD #1) _____ Age _____ CHILD #2) _____ Age _____

CHILD #3) _____ Age _____ CHILD #4) _____ Age _____

OTHERS _____

IF NOT MARRIED, ARE YOU IN A SERIOUS RELATIONSHIP NOW? _____ HOW LONG? _____

IF YES, NAME OF PERSON: _____ PHONE # _____

IS THIS PERSON MARRIED TO SOMEONE ELSE AT THIS TIME? _____

DO YOU PAY CHILD SUPPORT? _____ AMOUNT? _____ HOW MUCH BEHIND? _____

DO YOU RECEIVE ANY TYPE OF SUPPLEMENTAL INCOME? (SSI, FOOD STAMPS, CHILD SUPPORT) _____

AMOUNT: $_____ MONTHLY _____ WEEKLY _____ OTHER _____

NAME OF MOTHER: _____ LIVING/DECEASED? _____

RELATIONSHIP WITH MOTHER: _____

ADDRESS: _____ PHONE # : _____

NAME OF FATHER: _____ LIVING/DECEASED?_____

RELATIONSHIP WITH FATHER: _____

ADDRESS: _____

PHONE #: _____

NAME & AGE OF SIBLINGS:_____, _____,

_____, _____, _____

RELATIONSHIP WITH SIBLINGS:

_____

_____

OTHER FAMILY MEMBERS YOU MAY BE CLOSE TO: _____

EMERGENCY CONTACT: NAME: _____ PHONE: _____ EMAIL: _____

DO YOU HAVE A HIGH SCHOOL DIPLOMA? _____ COLLEGE DEGREES? _____

DO YOU HAVE A VALID DRIVER'S LICENSE? _____ DL#: _____ DO YOU HAVE A VEHICLE? _____

ARE YOU ON MEDICATION? _____ IF YES, WHAT KIND: _____

ARE YOU WILLING TO STOP TAKING MEDICATIONS THAT ARE NOT ALLOWED IN THIS MINISTRY? _____

(BENZODIAZEPINES AND OTHER NARCOTIC MEDICATIONS ARE NOT ALLOWED IN THIS MINISTRY, AS WELL AS ANY MEDICATION DEEMED UNACCEPTABLE BY LEADERSHIP.)

WHAT IS YOUR GENERAL STATE OF HEALTH?: _____

LIST ALL MAJOR ILLNESSES OR OPERATIONS YOU HAVE HAD:

_____

_____

ARE YOU DISABLED IN ANY WAY? _____

DO YOU HAVE ANY MEDICAL CONDITIONS THAT MIGHT AFFECT YOU WHILE YOU ARE HERE?

_____

DO YOU HAVE ANY SEXUALLY TRANSMITTED DISEASES?: _____

HAVE YOU HAD ANY IN THE PAST? _____ WHAT / WHEN? _____ CURED?: _____

LIST ALL CRIMINAL HISTORY/CHARGES:

_____

HAVE YOU EVER BEEN CONVICTED OF SEXUAL OR MOLESTATION CHARGES?_____

WHEN: _____

DO YOU HAVE ANY OUTSTANDING WARRANTS OR CHARGES AGAINST YOU NOW? _____

ARE YOU ON PROBATION? _____ COUNTY OF PROBATION: _____

NAME OF PROBATION OFFICER: _____ PHONE# _____

ARE YOU ON PAROLE?_____ LOCATION YOU WILL REPORT TO: _____

NAME OF PAROLE OFFICER: _____ PHONE# _____

HOW MUCH LONGER ON PROBATION/PAROLE? _____ FINES $:_____ FEES $: _____

WHAT IS YOUR REGULAR OCCUPATION OR VOCATION: _____

WHAT WORK SKILLS DO YOU HAVE: _____

HAVE YOU BEEN WORKING: _____ HOW MANY YEARS WITH COMPANY:_____

LAST TIME WORKED? _____

WHAT IS YOUR DRUG OF CHOICE:_____

LAST TIME USED or DRANK? _____ HOW LONG USING? _____

EVER BEEN TO DETOX UNIT:_____ HOW MANY TIMES? _____

EVER BEEN IN A PROGRAM BEFORE? _____

WHERE & WHEN: _____

_____

WHAT COULD PULL YOU OUT OF THIS PROGRAM? _____

IF WE HAVE A BED, ARE YOU READY NOW? _____ WILL YOU WAIT FOR A BED? _____

HOW DO YOU FEEL AFTER THIS INTERVIEW?: _____

_____

LAWYER NAME:_____

PHONE: _____ EMAIL:_____

I UNDERSTAND THAT I AM UNDER YOUR CARE AND DIRECTION WHILE I AM IN THIS PROGRAM AND RESIDE AT THIS FACILITY. I AGREE AND WILL COMPLY BY ALL THE RULE AND REGULATIONS AS LISTED.

SIGNATURE: _____ DATE: _____

STAFF SIGNATURE: _____ DATE: _____

GOOD SHEPHERD RECOVERY HOUSE FEE SCHEDULE

Updated 3/8/2022

$ 35.00	Background Check Fee **NON-REFUNDABLE**
$ 1,000.00	Basic Recovery Program (1 monthly communication with Supervising Officer). Includes bed, food, Recovery Program supplies, counseling, transportation to group events. Does NOT include specialty foods, individual transportation to appointments, etc. ALL FEES ARE NONREFUNDABLE. Payments must be RECEIVED by the LAST BUSINESS day of the month for the next month's Program. (October payment is due on the last business day of September.) **NON-REFUNDABLE**
$ 500.00	Intake Fee. **NON-REFUNDABLE.**
$ 100.00	Medical Exam and Testing Fee **NON-REFUNDABLE**
$ 10.00	Per each TYPE (EtG, 12 Panel, Nicotine, Synthetic, etc.) of Drug Test (if more than once per month is required). If Staff suspects drug use and the client is clean, GSRH will pay for the tests. Otherwise, the client will pay for any required additional tests.
$ 40.00	Per hair follicle drug test if required more than three times per year.
Calculation	Transportation charges - $0.585 per mile with standard gas prices b elow $4.00 per gallon. As fuel prices increase, so will the per mile p rice for transportation.
Value	Replacement value of any item broken by client

I understand and agree to the above-referenced fees.

Date Signature

Name

Good Shepherd Recovery House
601 Moore Rd.
Jasper Ga. 30143
678-459-2346

Re: Cost of this Ministry

The total cost of the GSRH program is determined by the payment option selected. Below are the current pricing schedule for our minimum twelve month program at GSRH.

1. $ 500 intake fee, with $1000 per month, which includes one (1) communication per month with the Supervising Officer / Department of Corrections. Minimum of $1,500 to become a resident.
2. If more communications are required, there is an additional cost of $250 per month.
3. If a Resident starts his stay after the first of the month, there will also be an additional prorated fee for their partial month stay.
4. All monies are due in our office or deposited to our account **no later than** noon on the last business day prior to the 1st day of the month.
5. **Sponsors are responsible for all payments throughout the 12+ month program. If the Resident is able to procure a job after Phase 1 (by the 4th month), his income can be applied toward his fees for the 5th month and thereafter. If the Resident is unable to pay for any portion of his program, the Sponsor is responsible for paying the remaining fees due.**

If for any reason the client leaves (failed drug test, violence, of their own choice, of their family's choice, etc.) there will be no refund on any monies paid to this Ministry and balance of tuition becomes due immediately.

Sponsor _____ Date _____

Client _____ Date _____

Staff Member _____ Date _____

Date Approved _____ by: Pastor/ Staff _____

** For Intake we need:

1. 3-5 page letter of request to enter facility.
2. Phone interview completed
3. Personal interview with Pastoral Staff at our facility, jail or otherwise designated common area meeting place.
4. This financial form satisfied (entrance fee paid)
5. Copy of rules and regulations signed.
6. Documentation from a **completed** Nurse Physical with Results of TB Test and Syphilis Test; and
   results from or proof of having bloodwork drawn for all other STDs, HIV, Hep A, B, C.
   If you are awaiting results from this bloodwork, then you must also show proof that you have completed a Release of Confidential Medical Information and that the medical office will send the results to Good Shepherd Recovery House. You can use the below Consent for the Release of Medical Information form.

Orientation Overview

This is a condensed summary of additional documentation you will be required to sign during your orientation.

- Look over the Intake Application section to make sure all necessary information is filled out. Sign the required pages and initial every page.
- We are a non-smoking, Christian 12+ month State Licensed and THOR Approved Drug and Alcohol Treatment and Education Program.
- Our curriculum requires Christian devotions, discipleship classes, 12-Step program and church. Much of our curriculum mentions scripture. You do not need to be a Christian or believe what we believe. However, you are expected to complete the curriculum, participate in discussions, and treat our beliefs with respect.
- You may use nicorette gum or patches to stop smoking over your first 8 weeks.
- We provide 1 written warning for breaking a rule. From thereon out, you receive Write ups and their consequences
    - 1st write up: Black out weekend - no phone, visitation or work,
    - 2nd write up: Black out weekend and 1 written assignment
    - 3rd write up: Black out weekend, 2nd written assignment, 1 week added to your graduation, and you are placed on a 30 day probation.
    - 4th write up in a month and you are dismissed from the program.
- On Wednesdays, you must attend five (5) hours of group counseling, so you cannot work on Wednesdays. You can work on Saturday, though.
- You cannot work outside of the House for a minimum of three (3) months, so you must be able to pay for your program and additional fees out of your own monies, or have a sponsor who will pay for your first 4 months plus intake fee. You can start working in the 4th month and begin paying for your program fees in the 5th month.
- Your first thirty (30) days are Blackout - no contact with family or friends except by written letters. You are on probation for those first 30 days. If you cannot get along with the other men or cannot follow the rules and guidelines, you will be released from our program.
- Visitation is every Saturday and Sunday afternoon. Visitation must be submitted and approved by the previous Wednesday.
- Passes begin in your 4th month. First 12 hour day passes every other week. Then overnight pass every other week. Then 2 night pass every other week. Passes must be submitted and approved on Wednesdays prior to the pass.
- We expect you to be as serious about your recovery as we are
- Romance and recovery DO NOT mix, no new relationships with the opposite sex, not even friends

- DO NOT continually ask for special favors, learn to adjust to your new environment
- You are responsible for your own mental and physical condition, we are not a facility specializing in that type of care. We will help you set up medical appointments and take you to them and to pick up medicine, but you are responsible for paying for your visits and medications.
- You assume all risks relevant to your stay here, you promise to follow all rules and regulations, and you will not sue GSRH for any matter that will arise during or because of your stay here
- You must return to GSRH every night unless on pass
- All mail will be opened
- Any items left after 3 days will be disposed of as GSRH sees fit
- Family/sponsor agreement: you will follow and uphold all GSRH decisions and cooperate with us fully
- 5 Big Areas: Tobacco, violence, pornography, alcohol, drugs - any infractions in these areas, on or off site, can get you dismissed immediately
- Cost of the program: $500 intake, $1000 monthly includes room, food, counseling, curriculum. Additional fees are stated in the attached Fee Page.
- The client or their sponsor is responsible to make payments by the last business day of the month before the new program month begins. There are no refunds for any reason and any monies owed are due immediately
- You will need to release Confidential info to your supervising officer, if you have one.
- You will provide authorization for us to receive medical information about you.
- You will provide an Approved contact list
- You break it you buy it; you run the bill up, you pay for it; if you see something wrong, say something about it
- We can search you, your room, your property and your vehicle at any time on any of our properties
- If you relapse and are honest, we can work with you; if you lie about it, you will be dismissed.
- Everything you see and hear regarding anyone in the program is confidential.
- There is a limited Approved medication list. No narcotics, no mood or sleep medicines unless REQUIRED by a doctor for health reasons.
- Liability and accident waiver; you assume all risks for yourself and cannot sue us
- If you feel you have been in any way sexually harassed or abused, you must report it immediately
- When you earn the privilege to work, all of your paychecks are delivered to Good Shepherd Recovery House for deposit into a joint Client bank account from which

you can retrieve $20 per week in pocket money, and additional approved monies for gas, food, etc.

- If you have a grievance, fill out a form and submit it for investigation and resolution.

Signature _____ Date _____

GOOD SHEPHERD RECOVERY HOUSE

APPROVED MEDICATION LIST

Allergy

- Claritin or generic equivalent (may NOT contain pseudoephedrine)

Cold and Flu

- Acetaminophen or Ibuprofen
- Saline nasal drops or spray
- Warm salt/water gargle
- Cough Drops or Throat Lozenges

Constipation

- Colace
- Metamucil

First Aid Ointment

- Bacitracin
- Neosporin or generic equivalent

Rashes

- Caladryl lotion or cream
- Hydrocortisone cream or ointment.

ADDITIONAL MEDICATIONS

Prescription medications such as antibiotics and antidepressants are generally acceptable but ***MUST*** be cleared with staff at the time of admission. Other medications used to manage cravings such as Naltrexone, Suboxone, Campral or Antabuse are on a case-by-case basis and ***MUST*** be cleared with staff at time of admission. Nicotine patches or gum may be purchased by the client and self-administered under Staff supervision as with all other approved medications, but for no more than four (4) weeks.

NON APPROVED

- ANY medication containing pseudoephedrine, diphenhydramine or dextromethorphan contained in brands such as Sudafed, Dayquil, Theraflu, Benadryl, Robitussin DM or any other "DM" cough syrup
- ANY prescription opiates of any kind such as in Tylenol #3, Percocet, Vicodin, Darvocet, Lortab, etc.
- ANY benzodiazepine including Ativan, Xanax, Klonopin, Valium
- ANY stimulant such as diet pills (including herbal remedies) or ADHD medications such as Adderall, Ritalin, Concerta, phentermine
- ANY sleep agents including Tylenol PM, Advil PM, Ambien, Lunesta, Sonata. THIS INCLUDES THE USE OF BENADRYL. (Melatonin is a safe alternative.)
- ANY preparations that have an alcohol base such as mouthwash and cough syrup.
- ___ANY steroids not prescribed by a doctor.

IF YOU ARE UNCLEAR ABOUT ***ANY* MEDICATION, ASK ***BEFORE*** YOU TAKE IT!!**

Client Signature:_____ **Date:**_____

Witnessed: _____

Good Shepherd Recovery House
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Re: Items allowed for intake

The following items are total number allowed for each item, you do not have to have this many but not more than what is listed below.

10 outfits (which includes church and work clothes combined)
2 Pajamas
4 pairs of shoes
10 pair socks and under clothes
2 jackets
2 Pillows
Personal items
- *Alarm Clock
- *Razors
- *Soap
- *Shampoo and Conditioner
- *Deodorant
- *Toothpaste & Toothbrush
- *Bible
- Paper & Pen
- Stamps & Envelopes
- **Christian music, magazines and books**

Note: Certain type Razors have to be approved by staff

Residents are NOT to share or give their personal items to others for any reason. If emergency arises GSRH will meet those needs.

In His Great Love,

Pastor/Director Ronnie Haynes

Good Shepherd Recovery House
601 Moore Rd.
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678-459-2346

Good Shepherd Recovery House

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

I, _____authorize
(Name of patient)
Good Shepherd Recovery House to acquire all medical records.

The purpose of the authorization in this consent is to: Document your progress in program attendance and participation.

I understand that my medical records gained will be used to best set my program structure. The two teams will work together for my best interest in my recovery.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: 90 days after completion or exiting program.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law.
I will not be denied services if I refuse to consent to a disclosure for other purposes.
I have been provided a copy of this form.

Dated: _____

_____ _____
Signature of client Signature of witness

_____
Print name of client Print name and title of witness