



WORTHY WOMEN TRANSFORMATION

MISSION & PROGRAM DESCRIPTION

MAIL/GIFTS:
Worthy Women Transformation
(WWT)
PO Box 116,
La Porte, IN 46352

Dear Reader/Applicant,

Worthy Women Transformation is a non-profit, Christ-centered residential ministry for women desiring freedom from addiction through biblical discipleship. We are a minimum 6-month program located in La Porte, Indiana. We exist to share the hope, power and freedom you desperately need, that is ONLY in Jesus Christ.

The mission of WWT is to teach you to renew your mind using the bible, so that you can put off your old self and be who God created you to be. **Romans 12:2 says: "Do not be conformed to this world, but be transformed by the renewal of your mind, that by testing you may discern what is the will of God, what is good and acceptable and perfect."** If you are willing to trust God, the Holy Spirit will empower you to change.

Worthy Women was established because our founder Sonshine Troche, idolized drugs, violence, men, and money for 20 years. She began mentoring female addicts in 2006, and witnessed one too many dying from addiction (idolatry). In 1993, Sonshine was on her way to prison for attempted murder. Sonshine had worked for 20 years as a dry-wall hanger/framer. She hired former male inmates after surrendering to Jesus on November 9, 1997. **She last used drugs on July 4, 1997 and surrendered to Jesus on November 9, 1997.** Sonshine has worked in a female juvenile program, owned Sonshine's Drywall & Repairs Inc., volunteered with the Christian Motorcyclist Association Prison Ministry, volunteered in the La Porte Co. Jail for 13 years, AND worked at the Westville Prison, (her mentor said: "You need to work at the Prison, to have any credibility!") Sonshine started the **Worthy Women Recovery Home, Inc. in 2008**, and opened in May of 2016. **November of 2023, WWRH became the Worthy Women Transformation Home.** WWT is a clean, safe, and structured 5000 square foot mansion with 3 bedrooms for 7 residents, with personal spaces for learning, growing in, and trusting God with all.

WWT is FREE for six months. HOWEVER, YOU CANNOT be employed. Some residents realize that they need to stay longer. Most women that come to WWT haven't worked for a long time or not at all. Residents can stay longer and work after 6 months, however fees will be charged on a sliding scale. **To be considered:**

- 1. The Applicant agrees to abstain from all romantic communications while she is a resident at WWT.** (Are you sick and tired of being lied to? If not, throw this application away or give it to someone.)
- 2. The Applicant agrees NOT to work at a place of employment for 6 months.** (How many times have you been rearrested after hurrying up and getting a job?)
- 3. The Applicant agrees to use her time at WWT productively and honorably!** (We want you to succeed for the rest of your life, not just to hurry and finish another program!)

A. Resident Responsibilities:

Each resident participates in daily activities such as exercising, bible reading and memorization, homework with reading and writing, weekly counseling, job skills training, help with creating a long-term treatment plan, and long-term life skills such as budgeting, cooking healthy, cleaning efficiently, planning and scheduling, etc.

B. Resident Programs and Training Material:

The Heart of Addiction, Relapse Biblical Prevention Strategies, Understanding Temptations, Cross Talk, Be TRANSFORMED (with 66 videos, written explanations, and questions to help you change your life for good), The Heart of Addiction, Relapse - Prevention Biblical Strategies, The HOPE Book, Truthfulness (instead of Honesty, Anger Management, Microsoft Office, Financial Responsibility, Long-term Life Skills, Job Skills training, and optional GED training.

If you desire FREEDOM from bondage, please continue. Galatians 5:1: It is for FREEDOM that Christ set us free.

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To be a peaceful resident at Worthy Women, you will honor the rules, the staff, the program, etc. Please write or call with questions or concerns. If you decide to be at Worthy Women, we **WILL** be patient as we guide you.

If you would like to apply to receive the support that so many before you were grateful for, then please:

- ✝ **Read and Complete** the Worthy Women Transformation Resident Application
- ✝ **Sign/Date and return** the Worthy Women Transformation Resident Application

Return the Application COMPLETED to:

WWT, PO Box 116, La Porte, IN 46352

OR

Scan to PDF and email to: worthy@wwtransform.org (to Staff, because confidentiality is critical!)

What to expect next:

- ✝ When we receive the Resident Application, it will be reviewed by WWT Staff.
- ✝ **Staff will schedule a phone interview if you send us your case managers/counselors/advocates name, and if it is allowed by the institution where you are incarcerated.**
- ✝ We will then send you an acceptance or a denial letter based on your responses.

Because of Jesus,

D. E. "Sunshine" Troche

D. E. "Sunshine" Troche, Executive Director
Worthy Women Transformation

Office: 219-325-3360 Email: worthy@wwtransform.org Website: www.wwtransform.org

WWT STAFF DISCRETION REQUIRES EACH POTENTIAL RESIDENT TO READ AND AGREE TO:

- 1) Respect the Worthy Women peaceful atmosphere, biblical morals, yourself, and others.
- 2) Dress modestly with ear piercings only, and with modest clothing that is not torn or revealing.
- 3) Use only the WWT house phone until cell phone privileges are earned and authorized.
- 4) Abstain from any personal, dating, romantic and sexual relationships, even if you are legally married.
- 5) Abstain from gambling and gambling paraphernalia.
- 6) Abstain from, not possess, or use alcohol including items containing alcohol: ex. perfume, mouthwash, etc.
- 7) Abstain from, not possess, or use any illegal, non-prescribed or unauthorized drugs.
- 8) Abstain from, not possess, or use any nicotine products, such cigarettes, vapes, lighters, matches, vapes, etc.
- 9) Abstain from, not possess, or use inappropriate or sexually explicit pictures or materials.
- 10) Not possess or use weapons of any kind and lock sharp hygiene items in your locker.

PLEASE READ: Blank lines on or below each section must be signed, initialed OR have N/A printed on it.

I, (Applicant full name signed), _____ confirm that I have read, understand, and agree with the WWT MISSION & PROGRAM DESCRIPTION written above. Date: _____

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STATEMENT of BELIEFS

(Adopted from the La Porte Missionary Church, La Porte IN)

Romans 12:2 Do not conform to the pattern of this world but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good, pleasing and perfect will.

1. We believe that God created Adam and Eve in His image, but when they were tempted and sinned in the garden, creation was alienated from God and cursed with sin. All of humanity is born under the curse of sin and as a result is deserving of divine judgement. It is only through the saving work of Jesus that we can be rescued from our rebellious state and have the wrath of God be satisfied.
(Romans 5:12-20; Ephesians 2:3)
2. We believe the Bible to be the inspired, the only infallible, authoritative Word of God.
(2 Timothy 3:16-17)
3. We believe that there is one God, eternally existent in three persons: Father, Son and Holy Spirit.
(Genesis 1; John 1)
4. We believe in the deity of our Lord Jesus Christ, in His virgin birth, in His sinless life, in His miracles, in His vicarious and atoning death through His shed blood, in His bodily resurrection, in His ascension to the right hand of the Father, and in His personal return in power and glory.
(Colossians 2:9; Hebrews 1:3; Philippians 2:5-11)
5. We believe that Salvation is by grace and faith alone in the finished work of Jesus (Ephesians 2:8-9) and that Jesus is the Only Way to have a right relationship with God.
(John 14:6)
6. We believe that for the salvation of lost and sinful people regeneration by the Holy Spirit is essential.
(Ephesians 1:13-14; Titus 3:5; Ezekial 36:26; 2 Corinthians 5:17)
7. We believe in the present ministry of the Holy Spirit by whose indwelling, the Christian is enabled to live a godly life.
(Romans 8; Acts 1:8; John 14-16)
8. We believe in the resurrection of both the saved and the lost; they that are saved unto the resurrection of life and they that are lost unto the resurrection of eternal separation from God.
(Romans 2:6-16; John 11:25-26; 2 Thessalonians 1:9; Hebrews 9:27)
9. We believe in the spiritual unity of believers in Christ.
(1 Corinthians 12; Colossians 3:1-4)
10. We believe in the purity of the marriage covenant between man and woman as created and designed by God according to His word, the bible.
(Genesis 1:27-28; 1 Corinthians 7:9; Matthew 19:5-6)

I, (Applicant full name signed), _____ confirm that I have read, understand, and agree with the WWT STATEMENT OF BELIEFS written above. Date: _____

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MEDICATION POLICY

POLICY: It is the Policy of WWT to be the advocate for the resident in discussing and obtaining all prescribed medications for the resident. Residents obtaining medication without permission will be terminated from WWT.

PROCEDURE: Residents must sign a consent form allowing trained WWT Personnel to be with resident for medical appointments and to inform all medical personnel of the medication policy. Staff must verify that prescribed medication container has the resident’s name, physician’s name, dosage, and count. **NOTE: WWT DOES NOT offer MAT. – Medication Assisted Treatment.**

“GREEN ZONE”	“YELLOW ZONE”	“RED ZONE”
Medications <u>ALLOWED</u> at WWT:	<i>Syringes are prohibited. Medications that require reason and listed seizure disorder to be documented by your doctor:</i>	Medications <u>NOT ALLOWED</u> at WWT include any “Controlled Substance”:
<u>Antidepressants</u> <i>Celexa, Cymbalta, Effexor, Elavil, Lexapro, Prozac, Paxil, Remeron, Savella, Zoloft</i>	<u>Mood Stabilizers & Seizure Meds</u> The following medications are allowed ONLY with Doctor’s documented seizure disorders: <i>Tegretol, Topamax, Trileptal, Lamictal</i>	<u>Anti-psychotics:</u> <i>Abilify, Geodon, Latuda, Mellaril, Seroquel, Clozaril, Haldol, Risperdal, Zyprexa</i> <u>Mood stabilizers-</u> <i>Lithium, Depakote, Abilify Mellaril, Clozaril, Risperdal, Geodon, Seroquel, Haldol, Zyprexa, Latuda</i>
<u>Anti-Anxiety Medications</u> <i>Buspar, Vistaril</i>		<u>Anti-Anxiety Medications</u> <u>Benzodiazepines-</u> <i>Ativan, Klonopin, Xanax, Valium, Librium</i>
<u>Sleep Aids-</u> <i>Trazodone and most over-the-counter sleep aids</i>	<i>Epi-pens can be used by insulin-dependent diabetics.</i>	<u>Sleep Aids-</u> <i>Ambien, Halcion, Lunesta, Restoril, Sonata</i>
<u>Non-habit forming ADD medications-</u> <i>Strattera, Intuniv</i>	<i>Vivitrol* can only be used if it is prescribed without injections/syringes.</i>	<u>ADD/ADHD Medication-</u> <i>Adderall, Concerta, Focalin, Provigil, Ritalin, Vyvanse or any other “controlled” medication.</i>
<i>Anti-inflammatory medications such as Ibuprofen, Meloxicam, Naproxen</i>		<u>Narcotic & Pain Medication-</u> <i>Codeine, Darvocet, Hydrocodone, Lortab, Lyrica, Oxycontin, Percocet, Tramadol, Ultram, Methadone, Suboxone</i>
		<u>Muscle Relaxants-</u> <i>Flexeril, Robaxin, Soma, Baclofen, Cyclobenzaprine, Gabapentin, etc.</i>
“GREEN ZONE”	“YELLOW ZONE”	“RED ZONE”

I, (Applicant full name signed), _____ confirm that I have read, understand, and agree with the WWT Medication Policy written above. Date: _____

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WWT RESIDENT APPLICATION

PLEASE READ: Blank lines on or below each section must be signed, initialed OR have N/A printed on it.

NOTE: We cannot accept Sex Offenders or most Violent Offenders.

Please be truthful as you voluntarily answer the questions below. We realize that your goal is to get out of prison and have an address or to keep from being locked up if you are in jail. However, for us to help you, we ask that you be detailed where requested or your application is subject to being denied. PLEASE PRINT LEGIBLY/READABLY

While you are a resident at WWT, you are prohibited from being in any romantic/intimate relationships, including all communications such as telephone, texting, or any form of social media. You will be terminated if you are caught breaking this rule. Signing below indicates that you are committed to following this rule while at WWT.

Applicant Signature: _____ Date: _____

APPLICANT'S PERSONAL INFORMATION

Name First: _____ Middle: _____ Last: _____

Birthdate (MM/DD/YEAR): ____/____/____ SSN: _____

Last address: _____

Street City State Zip Code

Do you have a: ___ Birth Certificate; ___ Social Security Card; ___ Driver's License # _____

Do you own a vehicle: ___ Yes ___ No. If yes, print the State and City: _____

Print the fees you owe: \$ _____ BMV; \$ _____ Courts; \$ _____ Probation; \$ _____ Other;

CURRENT SITUATION:

_____ I am a Military Veteran. _____ I am incarcerated. _____ I was incarcerated.

DOC #: _____ Facility: _____ County: _____ State: _____

_____ I may have a warrant(s). _____ I am in a shelter. _____ I am homeless. _____ I live with family.

Main Family Contact Name:

F- _____ M- _____ L- _____ Relation: _____

Best Phone Number: _____ Occupation: _____

Address: _____

Street City State Zip Code

Please list **two worst behaviors that you have** that you know you need to stop, and why you need to stop this?

1. _____ Why: _____

2. _____ Why: _____

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SPIRITUAL BACKGROUND – Please print answers in detail (Short, vague answers will void this application)**

1. A. Describe what you know about God, the creator of the universe? B. Can you trust Him, and why/why not?

A. _____

B. _____

2. A. Describe what you know about Jesus, the Son of God? B. Do you believe he exists, and why/why not?

A. _____

B. _____

EDUCATION - Please print the date & year on the line:

_____ Graduated High School; _____ GED; _____ College Degree: _____ AA; _____ BA

Please list special certifications: _____

RELATIONSHIP STATUS

I am: _____ Single, _____ Engaged, _____ Married, _____ Divorced, _____ Widowed.

_____ Spouse _____ Ex-Spouse's Name: First _____ Middle _____ Last _____

Birthday: ____/____/____ He ____ is incarcerated; ____ was incarcerated. His clean time: ____ months ____ years.

FAMILY - YOUR CHILDREN

Name of Child(ren) under age 18:	Age:	They Live in County/State:	They live with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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PRINT an X on the line in FRONT of your choice, ONLY where it applies. Otherwise, LEAVE THE LINE BLANK.

FAMILY – YOUR PARENTS/STEP-PARENTS RELATIONSHIP:

Relationship with my Father is: ___ Good; ___ Bad; ___ He passed. I saw him ___ Months ___ Years ago.

He: ___ used/uses Drugs/Alcohol; ___ was incarcerated; ___ is homeless; ___ works a lot; ___ is a good Dad.

He has/had: ___ Mental Health Issues; ___ SNAP or other benefits; ___ verifiable disabilities.

He abused me ___ sexually; ___ physically; ___ emotionally, ___ verbally.

Relationship with my Mother is: ___ Good; ___ Bad; ___ She passed. I saw her ___ Months ___ Years ago.

She: ___ used/uses Drugs/Alcohol; ___ was incarcerated; ___ is homeless; ___ works too much; ___ is a good Mom.

She has/had: ___ Mental Health Issues; ___ SNAP or other benefits; ___ verifiable disabilities.

She abused me ___ sexually; ___ physically; ___ emotionally, ___ verbally.

Relationship with my Stepfather is: ___ Good; ___ Bad; ___ He passed. I saw him ___ Months ___ Years ago.

He was/is: ___ using Drugs/Alcohol; ___ incarcerated; ___ Homeless; ___ works a lot; ___ a good Stepdad.

He has/had: ___ Mental Health Issues; ___ SNAP or other benefits; ___ verifiable disabilities.

He abused me ___ sexually; ___ physically; ___ emotionally, ___ verbally.

Relationship with my Stepmother is: ___ Good; ___ Bad; ___ passed away. I saw her ___ Months ___ Years ago.

She: ___ used/uses Drugs/Alcohol; ___ was incarcerated; ___ is homeless; ___ works a lot; ___ is a good Stepmom.

She has/had: ___ Mental Health Issues; ___ SNAP or other benefits; ___ verifiable disabilities.

She abused me ___ sexually; ___ physically; ___ emotionally, ___ verbally.

Your Sibling(s) Name(s):

Age:

Do they have any Felony Conviction(s):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTH

What type of Insurance do you have: ___ None ___ HIP ___ Medicaid ___ Private.

Your **Family Doctor's full name:** _____ **Office:** _____

Phone #: _____ **Street** _____ **+** _____ **City** _____ **State** _____

Allergies/Verifiable Doctor's Diagnosis:

Name of Doctor:

Doctor prescribed medication:

_____	_____	_____
_____	_____	_____
_____	_____	_____

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I've been admitted to a Psychiatric Facility: ___ Yes ___ No. Please list most recent admittance only.

City _____ State _____ Date of release ___/___/_____

I've been sentenced to a Addiction Recovery Program: ___ Yes ___ No. Please list most recent admittance only.

City _____ State _____ Date of release ___/___/_____

Is there anything else we may need to know about the above questions?

DRUG/ALCOHOL USE HISTORY

I use nicotine: ___ Never; ___ Occasionally; ___ Daily; ___ Weekly. ___ I Quit in _____.

My 1st drug/alcohol choice is: _____. I use/drink ___ Rarely; ___ Daily; ___ Weekly.

My 2nd drug/alcohol choice is: _____. I use/drink ___ Rarely; ___ Daily; ___ Weekly.

I use intravenous needles: ___ Never; ___ Occasionally; ___ Daily; ___ Weekly. ___ I Quit in _____.

The approximate age you first:

_____ used drugs/alcohol; _____ last used drugs/alcohol; _____ started smoking cigarettes;

_____ dated a drug/alcohol user; _____ moved out on my own; _____ admitted to my addiction.

PLEASE PRINT an X on the line before yes OR no. If yes, PRINT your age / ages. Examples: 6 – 12. 34

- Thoughts of self-harm ___ Yes ___ No. How old were you? _____
- History of Self-harm ___ Yes ___ No. How old were you? _____
- History of Violent Behavior ___ Yes ___ No. How old were you? _____
- History of Hearing Voices ___ Yes ___ No. How old were you? _____
- Loss of a family member ___ Yes ___ No. How old were you? _____
- Feelings of Anxiety or Fear ___ Yes ___ No. How old were you? _____
- History of STD/Infectious Disease ___ Yes ___ No. How old were you? _____
- History of Hepatitis ___ Yes ___ No. How old were you? _____
- History of HIV/AIDS ___ Yes ___ No. How old were you? _____
- History of Miscarriage ___ Yes ___ No. How old were you? _____
- History of Abortion ___ Yes ___ No. How old were you? _____
- History of Fainting ___ Yes ___ No. How old were you? _____
- Raped ___ Yes ___ No. How old were you? _____
- Victim of Domestic Violence ___ Yes ___ No. How old were you? _____
- Adopted ___ Yes ___ No. How old were you? _____
- Foster Care as a child ___ Yes ___ No. How old were you? _____
- Sexually Abused as a child ___ Yes ___ No. How old were you? _____
- Physical Abuse as a child ___ Yes ___ No. How old were you? _____
- Have/Had Homosexual Relationships ___ Yes ___ No. How old were you? _____

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The APPLICANT must fill the rest of the forms out completely to be considered at WWT.

NOTE: All of your information is kept confidential and will ONLY be shared with the WWT Staff, IF, once you enter the WWT program as an official resident, the information is needed for treatment.

WWT MEDICAL CONSENT FORM

Name of Applicant: _____ Date: _____

Worthy Women Transformation is not a medical care provider, and does not have any medical staff.

I _____ (Printed Applicant Name) hereby authorize WWT personnel to act on my behalf under the following conditions:

You verbally request emergency assistance. You are found unresponsive and unable to request emergency assistance. WWT authority deems a situation you are a part of to be an emergency.

By signing below, you are granting WWT personnel permission to call 911 and/or emergency services on your behalf. **You will be responsible for any and all costs associated with these emergency services.**

Applicant Signature: _____ Date: _____

WWT RESIDENT RELEASE AGREEMENT

The undersigned (the potential resident) acknowledges, fully understands, and agrees to the following:

DEFINITIONS

- 1. "Worthy Women Transformation" means Worthy Women Transformation (WWT), PO Box 116, Physical Address is confidential to avoid distribution to uninvited friends of residents, La Porte, Indiana 46350.
- 2. "WWT premises" means the building and grounds owned by Worthy Women Transformation.
- 3. "The undersigned" means the Applicant/Potential Resident: _____.
- 4. "Released Parties" means the directors, officers, board of directors, employees, staff, volunteers, agents, members, interns, and other residents of WWT, affiliates or ministries of WWT, La Porte, IN.

RELEASES AND ACKNOWLEDGEMENTS

5. DAMAGE CLAIMS:

The undersigned hereby **releases** the Released Parties from any claim, injury, death, property loss, property damage, or cause of action of any nature relating to me, arising on, at or near the WWT premises, or while being transported to, from, or during any activity planned by or sponsored by WWT, including claims for damages from any cause directly or indirectly relating to any action or failure to act by any of the Released Parties, and whether or not it is alleged that any Released Party in any way contributed to the alleged wrongdoing or is alleged to be based upon a non-delegable duty. This release is intended to also release the Released Parties even if there is alleged to have been negligence or gross negligence by any of the Released Parties, and this release also relates to any possible claims, whether known or unknown, and whether they are possible or impossible to be known at the time this release is signed. **APPLICANT INITIALS** _____

6. PERSONAL ITEMS 1:

It is considered a matter of grace and privilege that the undersigned may keep clothes, personal items or other property at the WWT premises, and the consent of WWT for the undersigned to keep such clothes, personal items and other property at the WWT premises ends immediately and automatically if the undersigned resident of WWT

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leaves or is dismissed. Accordingly, if the undersigned has not completely removed any clothes, personal items or other property within 24 hours after leaving or being dismissed, such clothes, personal items and other property shall be deemed forfeited and abandoned, and may be disposed of in any manner whatsoever by WWT.

APPLICANT INITIALS _____

7. PERSONAL ITEMS 2:

Any clothes, personal items or other property of the undersigned are and remain at the risk of the undersigned and WWT shall have no responsibility relating thereto. If any clothes, personal items or other property of the undersigned are or become missing, stolen, or left, WWT has no responsibility or liability relating thereto (see also Paragraph 5 above). **APPLICANT INITIALS** _____

8. MAIL INSPECTION:

WWT is a rehabilitation treatment ministry and it is required that communications to or from residents be carefully monitored. The undersigned specifically grants consent and permission to the Executive Director of WWT, and any person designated by her, to open all of the incoming and outgoing mail of the undersigned, and the Director shall have the prerogative to share the contents of any such mail to others (staff/counselors) on a need-to-know basis.

APPLICANT INITIALS _____

9. PRIVACY, SEARCH & SURVEILLANCE:

WWT takes responsible and necessary steps to protect the residents and staff of WWT. By participating in the WWT Rehabilitation Program, the undersigned **voluntarily relinquishes** her "expectations of privacy" and "rights of privacy" as they relate to all areas of the WWT Premises, and to the clothes, personal items and other property of the undersigned, which are brought by the undersigned to the WWT premises. The belongings of the undersigned upon arrival at WWT will be checked and searched, and will remain subject to search so long as the undersigned is involved in the WWT Program. This includes the undersigned's vehicles, bathroom and bedrooms. See Procedure below. **APPLICANT INITIALS** _____

10. FOLLOWING RULES:

The undersigned voluntarily and fully adheres to follow the WWT Program, its rules and schedules. The undersigned recognizes and acknowledges the leadership of the WWT Board of Directors, Staff, Interns, and Volunteers and the undersigned promises to follow the WWT rules, schedules, requirements, and the directives of the WWT Staff. **APPLICANT INITIALS** _____

11. CONSEQUENCES:

If the undersigned chooses to disregard the WWT rules or schedule, or disregards directives of the WWT staff, or otherwise rebels against the staff of the WWT Program, the undersigned may, at the sole discretion of WWT, be dismissed from the program, and if the undersigned is so dismissed, she will leave the WWT premises as soon as possible thereafter, taking with her all of her personal items and property. **APPLICANT INITIALS** _____

PROCEDURES FOR NEW RESIDENTS, INCLUDING SEARCH PROCEDURE:

1. **Step One in the Receiving Process** – A WWT Staff person will complete the Release agreement and all intake orientation paperwork with the resident. Staff will take a digital picture of the resident by herself.
2. **Step Two in the Receiving Process** – A safety search will be performed with the resident in the main bathroom with an authorized staff member present.
 - A. The resident will use a towel or wear a robe with her back to staff, to cover herself with, prior to undressing to her undergarments.
 - B. **Staff are not permitted to touch the resident's body.**
 - C. Resident will stick out her tongue, move it up and down and sideways.
 - D. Resident will lean forward, sliding her fingers through her hair while moving her head back and forth.
 - E. The Resident will squat by bending the knees at a 90-degree angle, and cough deeply 4-5 times, allowing any concealed item in her body cavities to be loosened and dislodged.
 - F. The staff must exit the room **before** the resident removes the robe to shower or to put her clothes back on once the search is completed.

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3. **Step Three in the Receiving Process** – Each new resident will undergo a drug screen, no-contact body check, and basic health screen with a female Staff member of Worthy Women Transformation. Body checks must happen in the presence of female Personnel only.
4. **Step Four in the Receiving Process** The "Resident inventory sheet" will be completed. This will account for all personal belongings.
 - A. Staff will thoroughly examine belongings for prescriptions, street drugs, cigarettes, inappropriate music, or any other item posing potential harm to residents or contrary to program philosophy.
 - B. All luggage, bags and the contents of the resident's purse, as well as all clothing will be reviewed thoroughly, examining all pockets and the linings.
 - C. All folded items will be unfolded.
 - D. Each item will be recorded on the Resident Inventory sheet, providing a description of each item.
 - E. All prohibited items will be disposed of by WWT staff, per the resident's pre-intake MISSION & PROGRAM AGREEMENT SIGNATURE.
5. **Procedures for Room Inspections:**
 - A. The purpose of the room inspection is to keep both staff and residents safe.
 - B. Room inspections will include both the furnishings in the room as well as the residents' personal belongings.
 - C. Room inspections will be conducted by staff or an intern and will always occur in the presence of one witness who may be staff, an intern, or a volunteer.
6. **When there is a reason to inspect a room, the following procedure will be followed:**
 - A. The resident will be informed that a room inspection is being conducted and will be required to be present.
 - B. Staff and a witness will complete the inspection, and the room will be returned to the original order when the inspection is complete.
 - C. Any item not allowed will be documented, removed, and discarded. Prohibited items may result in consequences or termination of the WWT Program.
 - D. Staff will document the inspection noting any items not allowed and their disposition.
 - E. The resident and staff present will sign the search consent form before search and after the search. Refusal to sign by resident will result in termination of the WWT Program.

WWT RELEASE AND DISCLOSURE OF INFORMATION

I will receive a copy of all documents if I am accepted to WWT. I, _____, authorize the following individuals, medical providers and agencies to share, provide, release, communicate about, discuss and exchange information, records and documents, regarding my history, my medical, psychological and mental records, and any other appropriate data with WWT personnel. This release to WWT personnel includes, but is not limited to, the release, delivery and/or disclosure of facts, information and documents relating to my medical and/or psychological diagnosis and treatment, records, reports, x-rays, photo static copies and/or electronic data. The purpose and need for disclosure **of information** is to provide collaboration with the **listed** entities regarding my attendance, progress, and attitude toward my evaluation and required treatment. The extent of necessary information to be disclosed includes:

- | | |
|-------------------------------------|----------------------|
| 1. Attendance | 4. Required Services |
| 2. Prognosis | 5. Completion |
| 3. Results of Drug / Alcohol Screen | 6. _____ |

I understand that the provision of services by WWT is not contingent upon my signing this document. I understand that I may revoke this authorization at any time except to the extent that action has already been taken using this authorization. This authorization will be valid during my application process, during my residency at Worthy Women Transformation and for 365 days after discharge/termination of services with Worthy Women Transformation.

Examples of Services needed: Resident Family members (up to 4(FM), Probation & Parole Officer, Doctor(s), Pharmacy, Counselor, WWT Personnel, Religious Leader, Spouse, Employer)

1. FM _____ 6. _____

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- 2. FM _____ 7. _____
- 3. FM _____ 8. _____
- 4. FM _____ 9. _____
- 5. _____ 10. _____

I understand that the recipients of this information may re-disclose it only in connection with their official duties.

Applicant Signature Date

ADDITIONAL THOUGHTS OR NEEDS/WANTS OF THE APPLICANT

In the applicant’s own words, please write why you want to be a resident at WWT and what else we need to know.

DISCLAIMER:

We will only take biological women (born as a female). Worthy Women Transformation will not pay for any medical needs and/or prescribed medicine for residents. Applicants should be in general good health, on minimum medication (2-3) and able to lift, walk, carry, think, listen, perform normal duties such as cleaning, cooking, shopping, helping others, learning/being humble and have a grateful attitude often.

PLEASE think about your health needs to determine if we are a great fit for your addiction rehabilitation needs. Doctor’s appointments will be made if a life-threatening issue arises. You will be accompanied by a volunteer or staff of WWT and you will never go to any medical office or pharmacy by yourself. This is to protect you while you are learning to be strong in Christ, and to protect our home from any unauthorize prescription you may be tempted to obtain. James 1:14 in the bible, says, ...but each person is tempted when they are dragged away by their own evil desire and enticed.) We want the best for you and we expect you to do your best while at WWT.

Psalms 37:4 - Delight yourself in the LORD, and He will give you the desires of your heart.

PLEASE review the application to make sure you did not miss anything.

By signing below, you are indicating that if accepted, you agree that you are being truthful in this application, and that you will honor the staff, the program, the volunteers, and yourself while at Worthy Women Transformation.

APPLICANT SIGNATURE: _____ **DATE:** _____

Mail to: WWT, PO Box 116, La Porte, IN 46352 **Email:** worthy@wwtransform.org **Office:** 219-325-3360

WWT OFFICE USE ONLY:

Staff Interviewer: _____ **Date Staff called:** _____

Name of IDOC or Jail: _____

Advocate for Applicant: _____ **Advocate Phone:** _____

Applicant Accepted: _____ **Reason for Denial:** _____

STAFF SIGNATURE/TITLE: _____ **DATE:** _____