



Esther House Program Application

Please note: If you need assistance with interpreting and /or completing this application, please ask the person who gave you the form; they will be happy to help. You are welcome to dictate your answers verbally.

We are pleased you are interested in applying for the Esther House Program. Esther House and The Pregnancy Center are a Christ-centered ministry providing alternatives to abortion and support programs committed to saving lives, physically, spiritually, and emotionally one life at a time, for the Glory of God. The Esther House Program is a transitional living program for 18 months that will assist you in reaching your goals of living independently. Esther House will provide spiritual, emotional, physical, and mental support to help you and your child(ren) gain the skills and confidence to become independent.

The staff only uses this application to determine your eligibility and whether this program can meet your needs. The questions in this application are solely a way to help to discover if this program will be a good fit for you. Please answer all questions to the best of your ability; if there is a question that you would rather answer in your interview, please write that in. All answers are confidential.

Please complete this application in person and in its entirety. Once completed, please return it to the front desk, and they will schedule your interview. The interview will take place at The Pregnancy Center.

Thank you for your interest in the Esther House Program. We look forward to meeting with you soon!



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Eligibility Criteria

The determination of acceptance into Esther House is based on the following minimum criteria and guidelines.

Applicant must be:

- ◆ Pregnant in any trimester.
- ◆ Currently homeless or about to be homeless.
- ◆ Must be at least 18 years of age.

Transitional Housing Information

Esther House will provide the following:

- ◆ Shelter that includes all utilities, some meals, and laundry.
- ◆ Parenting Classes.
- ◆ Life Skills, such as cooking, budgeting, and how to reach goals.
- ◆ Advocacy and spiritual, emotional, mental, and physical support, including case management.
- ◆ Assistance in how to find and maintain independent housing.
- ◆ Education, Vocational, and Employment assistance.
- ◆ Referrals to community resources and services.



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Applicant Information

Today's date: _____

Full Name (Last, First, & M.I.): _____

Please List Any Other Names Used (Maiden or Alias): _____

Age: _____ Date of Birth: Month _____ Day _____ Year _____

Marital Status: Single, Married, Separated, Divorce

Driver's License or State I.D. #: _____ State Issued: _____

Social Security Number (**Only used for background checks**) _____

May we contact you? Yes No Telephone Number: _____

Alternative Number: _____

May we leave a Voicemail Message? Yes No

May we send you a Text Message? Yes No

May we email you? Yes No Email Address: _____

How did you hear about the Esther House Program? _____

Are you a Legal U.S. Citizen? Yes No If answered no, are you willing to work with an Immigration Attorney to become a Legal U.S. Citizen? Yes No

What is your preferred language? _____

Are you able to understand (verbal and/or written) English? Yes No

Do you have a Service Animal? Yes No



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If they answered yes, are they current with their licensing and vaccines? Yes No

Current Living Situation

Where are you currently staying? Street Address: _____

City: _____ State: ____ Zip Code: _____

How long have you been at your current address? _____

Are you currently or about to become homeless? Yes No

If you are currently homeless, how long have you been homeless? _____

Are you in a safe place while your placement with Esther House is determined? Yes No

If you answered no, would you like someone to contact you with options for emergency shelter? Yes No

If you are not in a safe place, how would you like us to contact you about the Esther House placement decision? _____

Names and Ages of any children coming into the program with you (please note, they must be 11 or under): If none, please write N/A:

Name:	Ages:	Sex:	Name of School:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



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Do you have any children awarded to the state/in foster care? Yes No

If answered yes, please explain why they are awarded to the state/in foster care

If yes, are you allowed to have contact with them? Yes No

If allowed to have contact with your child(ren) and they are under the age of 11, would you be interested in the Reunification Program? Yes No

Health History

Do you currently have Health Insurance, whether private or state? Yes No

How would you rate your current health? Excellent Fair Poor

Do you have a Primary Physician? Yes No

Name of Physician: _____ Name of Clinic: _____

When was your last visit with your primary physician? _____

Please list any diagnosed health conditions you have, i.e., Diabetes, Insulin Resistant, Cancer, Heart Disease:

Condition: Date Diagnosed: Currently Under Treatment:

_____	_____	
_____	_____	
_____	_____	

Yes No

Yes No

Yes No



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Yes No

Please list any medications, including over-the-counter, prescribed, and supplements, as well as the dosage of each you are currently taking:

Name of Medication:

Dosage:

Prescribed:

_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any changes you want to make for your health? Yes No

Mental Health History

Are you a Domestic Violence Victim/Survivor? Yes No

If you answered yes, have you received any aftercare/grieving care? Yes No

If not, would you like to receive aftercare/grieving care? Yes No

Are you a Victim/Survivor of Human Trafficking? Yes No

If you answered yes, have you received any aftercare/grieving care? Yes No

If not, would you like to receive aftercare/grieving care? Yes No

How would you rate your current mental health? Excellent Fair Poor

Do you see a counselor? Yes No

Name of counselor: _____ Name of Clinic: _____



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When was your last visit with your counselor? _____

Please list any diagnosed mental health conditions you have, i.e., Depression, Anxiety, Schizophrenia, Borderline Personality:

Condition:	Date Diagnosed:	Currently Under Treatment:
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any medications, including over-the-counter, prescribed, and/or supplements and dosage you are currently taking:

Name of Medication:	Dosage:	Prescribed:
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any changes you want to make for your mental health? Yes No

Pregnancy Information

Is this your first Pregnancy? Yes No

If you answered no, how many pregnancies have you had? _____



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How many Live Births? _____

Have you had any miscarriages? If so, how many? _____

Have you had any other pregnancy-related complications? Yes No

If you answered yes, please explain: _____

Is your pregnancy considered a high-risk pregnancy? Yes No

If you answered yes, please explain: _____

Have you had any abortions? If so, how many? _____

If you answered yes, have you received any aftercare/grieving care? Yes No

If not, would you like to receive aftercare/grieving care? Yes No

Are you currently receiving pre-natal care from an OBGYN? Yes No

How many weeks along are you in your pregnancy? _____

When is your exact Due Date? _____

Is the father of the baby aware that you are pregnant? Yes No

If you answered no, please explain: _____

Have you refrained from using all street drugs, alcohol, and Marijuana? Yes No

If you answered no, please list the substances you have been using and the date of last use:

Substance:

Last Date Used:

Are you willing to get help:

Yes No



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Yes No

Criminal History

List all charges, outcomes, and whether drugs/alcohol were involved; if none, please write N/A:

Charges:

Outcome:

Drugs/Alcohol Involved:

_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you on probation or parole? Yes No

If on probation, how long is your probation period? _____

If applicable, please list your probation or parole officer: _____

Do you have any warrants out for your arrest? Yes No

If you answered yes, please explain: _____



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Do you have a no-contact or restraining order against anyone? Yes No

If answered yes, please list their name(s): _____

Does anyone have a no-contact or restraining order against you? Yes No

If answered yes, please list their name(s): _____

Education, Employment & Income History

Highest grade completed: 8th 9th 10th 11th 12th

Did you receive a diploma or GED? Yes No

Are you currently attending, or have you attended College? Yes No

If yes, what was your major? _____

Did you receive a degree? Yes No

List any licenses or certificates you have received: _____

If not currently attending college, are you interested in job training or college? Yes No

Please list employment history, starting with the most recent:

Name of Employment: Start Date: End Date: Reason for Leaving:

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

List your source of Income; if none, please write none:

Source: Amount: Frequency (i.e., monthly):

_____	_____	_____
_____	_____	_____



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Do you receive TANF? Yes No Amount: _____

Do you receive Food Stamps? Yes No Amount: _____

Do you receive WIC? Yes No

List any other sources of supplemental income, amounts, and frequency:

Source:

Amount:

Frequency:

Drug & Alcohol History

Have you ever experimented with drugs and or alcohol? Yes No

If yes, what was the outcome? _____

Age first experimented/used drugs? _____

Age first experimented with alcohol? _____

Last time you used drugs: _____ Last time you had a drink: _____

How often/Amount of drugs/alcohol did you consume? _____

Do you consider yourself to be an addict? Yes No

Drug of choice? _____

What were the consequences of your drug/alcohol use? _____

List your Clean Date. _____

Did you receive in-treatment/out-treatment for your addiction? Yes No

If yes, where and what was the outcome? _____



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Do you have an After-Care Plan for your addiction? Yes No

Are you currently attending a Recovery Treatment Support Group? Yes No

List two to three goals you wish to obtain if accepted into the program: _____

Community Resource

We can provide various resources if you are not accepted into Esther House. Please put an X on the type of resources you want, and we will do our best to provide you with information.

- Connecting with a Church
- Other Housing Transitional Programs
- Assistance with Employment Programs
- Mental Health
- Alcohol/Drug Recovery Treatment
- WIC
- Food Stamps
- Food Pantries
- Utilities' Assistance
- Rent Assistance
- Youth Involvement
- Other _____

Please note that this is an application and does not necessarily guarantee a spot in Esther House. If you are eligible, someone from the Pregnancy Center will schedule an interview with the program manager; you may need to supply additional information. Thank you!



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Office Use Only

Was the interview Process completed? Yes No If no, please explain: _____

Accepted into Esther House? Yes No

If yes, date of notification to the applicant, and by which means:

Date of Tour of Facility _____

Was the applicant placed on a waiting list? Yes No If yes, date: _____

If not, what reason? _____

If not accepted, date of notification to the applicant, and by which means: _____

Reason for denial: _____

Was the applicant provided information about the appeal process? Yes No

Have community Resources been given? _____
