St. Gianna's Place, Inc.

A Safe Harbor For Mother and Child

P.O. Box 725 Londonderry NH 03053 603.521.8440 StGiannasPlace.org

SCHOLARSHIP APPLICATION

Please Print Clearly **Date:** ________________

GENERAL

Full Name: ____ Maiden: _______________________

DOB: ______________________ Age: __________ Social Security Number: _______________________

Last Address (street): ________________________ (City & State) _______________________________

Last Home Phone: ________________ Work Phone: ________________ Cell Phone: _________________

Do you have a driver's license? Yes No Do you have a car? Yes No

Driver's License Number: ________________ State: ________ License Plate Number ________________

Last Address Was: Own Apartment With Friends/Family Shelter Other: _________________

Have you been homeless before? Yes No Have you stayed in a shelter before? Yes No

Place of Birth: ____ U.S. Citizen Yes No

Marital Status: Single Married Separated Divorced In a Relationship

Please list any other children you have (use the back of the page if needed):

Name	DOB	Gender	Name / Address of Guardian

Father of this Pregnancy / Child: ________________________ Current Relationship: _________________

Domestic Violence? Yes No If Yes: Mental/Emotional Physical Verbal Sexual

Name of Abuser: ____ Relationship: __________________

Are you currently in the abusive relationship? Yes No

Do you have a restraining order against the abuser? Yes No

Please Print Clearly

LEGAL

Were you ever arrested for assault? Yes No When? ________________________________

Have you ever been convicted of a felony? Yes No

Charge: ____ Date Charged: ____________________

Results of trial: ____

Probation Officer: __________________________________ Phone: _______________________

Have you ever been involved in any other legal situations? Yes No

(Divorce, Arrests, Warrants, Legal Guardian, Probation, Restraining order, etc.):

____

EDUCATION & EMPLOYMENT

Are you currently in school or working on a degree? Yes No

Highest grade completed: ____________ Have you had any vocational training? Yes No

Are you employed? Yes No If Yes: Monthly pay $______

Employer: _________________________________ Supervisor: __________________________

Address: _______________________________________ Phone: ________________________

How long have you been with this employer? ______

FINANCIAL

Do you have any income? Yes No If yes: Monthly Total: $ _______

Please circle all you receive: Food Stamps Medicaid TANF APTD SSI WIC

Child Support Child Care Other (Please Specify): ________________________________

Do you have medical insurance? Yes No Name of insurance: ________________________

Do you have any outstanding bills? Yes No

Please circle all outstanding bills that apply: Housing Utilities Phone Car Medical

Credit Cards School Loans Other: ____

Please Print Clearly

FAMILY HISTORY

Please give us the following information about your parents: (Release signed if applicable)

Mother's Name: ______________________________ Phone: ____________________

Street Address: ______________________ City, State, Zip: ________________________

Father's Name: ______________________________ Phone: ____________________

Street Address: ______________________ City, State, Zip: ________________________

HEALTH

Are you currently receiving medical care? Yes No Date of last visit: ________________

Due Date: ____________ Have you had any previous pregnancies? Yes No

Have you previously had any: Live Births Miscarriages Abortions Other ____________

Primary Care Physician's Name: ____

Primary Care Physician's Practice Name: ______________________Phone: ______________

Address: ____

OB/GYN's Name: ____

OB/GYN's Practice Name: ______________________________Phone: ______________

OB/GYN's Practice Address: ____

DELIVERY PLAN

Hospital of choice: _____________________ Delivery Partner: ______________________

Relationship: ________________________ Phone: ___________________________

Special Instructions: ____

____

ARE YOU...

☐ On a special diet? If yes, explain: ____

☐ Allergic to any medications? If yes, please state: _____________________________

☐ Allergic to any foods? If yes, please state: __________________________________

☐ Allergic to anything else? If yes, please state: _______________________________

If you have allergies, please explain symptoms and reactions: ______________________________

____

What precautions and treatments do you use for your allergies? ____________________________

Please Print Clearly

Have you ever worn glasses or contacts? Yes No Other issues: ______________________________

Do you have any dental problems? Yes No When was your last dental exam? ________________

List all medications you take (including over the counter):

Medication	Dosage	How often do you take it	Condition it is used to treat

Do you smoke cigarettes? Yes No If yes, how many per day? ______________________________

Have you consumed alcohol or drugs during your pregnancy? Yes No

If yes, please specify: ______________________________

Have you ever: Been hospitalized? Yes No Had surgery? Yes No

If yes, please explain: ______________________________

Have you ever had PPD Testing? If yes, date given: ____________________ Results: ______________________

Circle any of the following you have or have ever had:

Chicken Pox	Hepatitis B	Mental Illness	Yeast Infection
Depression	Hepatitis C	Mononucleosis	Other:
Diabetes	Hernia	STDs:	__________________
Diverticulitis	Hives / Rashes	Chlamydia	__________________
Exposure to Tuberculosis	HPV/Genital Warts	Gonorrhea	__________________
	Known HIV Contact	Herpes	
Eye Infections	Liver Disease	Other STDs Not Listed	
Hepatitis A	Measles	Thyroid Disease	

Please state any additional medical information we should know: ______________________________

____

Did you have any complications that resulted from childhood diseases? Yes No

Have you ever had any counseling? Yes Currently No

Counseling Center: ____________________________ Name of Counselor: ______________________________

Address: ____ Phone: __________________

Please Print Clearly

Mental Health Diagnoses:

Bipolar Depression Anxiety Other ______________________________

Current Psychiatric Medications: ______________________________

Past Psychiatric Medications: ______________________________

Have you ever been hospitalized for mental health reasons? Yes No When? ______________

Have you ever attempted suicide? Yes No When? ______________

What kind of attempt did you make? ______________________________

Do you have a history of substance abuse? Yes No (circle drugs of use):

Alcohol Amphetamines Barbiturates Cocaine Crack Heroin Marijuana

Other Street / Club Drugs Prescription Medication

When was the last time you used alcohol or drugs? ______________________________

Have you completed a drug treatment program? Yes No

Name of program: ______________________________

Address: ______________________________ Phone: ______________

Are you taking: Methadone? Yes No Are you taking Suboxone? Yes No

Have you ever engaged in any "High Risk" behavior? Yes No

(sharing needles, unprotected sex, etc.)

Are you a victim of sexual abuse? Yes No

Are you a victim of sex trafficking? Yes No

EMERGENCY CONTACT:

Name: ______________ Relationship: ______________ Phone: ______________

Street Address: ______________________________ City, State, Zip: ______________

____

ANYTHING ELSE YOU WANT US TO KNOW:

APPLICANT'S CERTIFICATION:

My signature below confirms that I have read, understand, and agree to abide by the Guidelines of St. Gianna's Place. My signature also confirms that the information I have provided to St. Gianna's Place is true, accurate, and honest. If any information that I have provided is indeed false, I understand that St. Gianna's Place may ask me to leave the program immediately. I absolve St. Gianna's Place from any liability of any actions they may take based on this information that I have provided as truth.

______________________________ _______________

Applicant Signature Date

______________________________ _______________

Director Signature Date

Please Print Clearly

LIABILITY RELEASE FORM

I,____________________________________, enter of my own free will into the following agreement with St. Gianna's Place:

1. I have had the rules of the house clearly explained to me and agree to abide by them.
2. I understand and agree that St. Gianna's Place shall incur no liability in the event that I fail or refuse to stay in the home.
3. I agree I will vacate St. Gianna's Place within 48 hours, or sooner if deemed necessary, upon the request of any authorized St. Gianna's Place personnel.
4. I agree that in accepting shelter from St. Gianna's Place, I will in no way hold them responsible or liable for:
   a) any debts, personal injuries, losses through fire or theft which may result of my association with them while I reside at St. Gianna's Place.
   b) any complications relating to my pregnancy, labor, delivery or any other aspect of my association with them.
5. I grant permission for any staff or representative of St. Gianna's Place to inspect my belongings and/or my room at any time and remove from them any liquor, drugs, drug paraphernalia, medication or weapons.

____ ________________

Applicant Signature Date

____ ________________

SGP Representative Date

Please Print Clearly

MEDICAL SERVICES FOR CHILD

I,________________________________, give permission for my child/children to receive medical and/or dental services in the event of an emergency, accident, or illness, when I am not present and cannot be reached immediately.

	Names of Children:	DOB:	Social Security#:
1.	______________________	__________	____________________
2.	______________________	__________	____________________
3.	______________________	__________	____________________

________________________________ ____________

Applicant / Resident Signature Date

Please Print Clearly

Information Release

Agency Name: ______________________________

Agency Address: ____________________________

City, State and Zip: _________________________

Agency Phone Number: ______________________

Agency Fax Number: ________________________

______________________________ authorizes a two-way exchange of information between St. Gianna's Place and the above party. She understands this release to encompass all information including: psychological testing, medical history/records, legal records, counseling records, educational information, and drug/alcohol information.

_________________________________ ____________________

Applicant/Resident Signature Date

_________________________________ ____________________

Director's Signature Date

Please Print Clearly

Information Release

Agency Name: ______________________________

Agency Address: ____________________________

City, State and Zip: __________________________

Agency Phone Number: ______________________

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__________________________________ ____________________

Applicant/Resident Signature Date

__________________________________ ____________________

Director's Signature Date

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Agency Address: ____________________________

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_________________________________ ____________________

Applicant/Resident Signature Date

_________________________________ ____________________

Director's Signature Date