Program Application

Agape Home for Women & Children | Men's Ascent Program

Program Information

Agape Home and the Ascent Program are residential recovery programs for individuals seeking to make a change in their life. Individuals entering into these programs should plan to make a 12-month commitment.

Lighthouse Mission Ministries (LMM) understands recovery to be a process of life transformation. Our desire is to help you go after the root behind the behaviors which you've lost the ability to control. For some people these behaviors may involve substance use, while others may need recovery from codependency, gambling addictions, sex addictions, or any number of other things. These "process addictions" will be evaluated case-by-case so we can ensure our ability to serve you well.

The Agape Home and Ascent Program use evidence-based strategies to provide support to individuals seeking recovery. Program residents can expect to engage in 12-step meetings or other recovery groups, attend classes, weekly case management sessions, and a variety of faith-based activities.

This program might be for you if:

- You're able to identify a need for recovery
- You're willing to work with our team on personal change
- You have the ability (or are willing to learn) to live in a community environment
- You're willing to put other things in your life (such as employment) on hold for a period of time to focus on your recovery

This program may not be a good fit for you if:

- You are not ready to commit to a long-term residential program
- You are not willing to abstain from all recreational substances (including cannabis and kratom)
- You are not willing to sign a complete Release of Information for your providers
- You are primarily looking for affordable housing options and not interested in structured programming

Application Instructions

To Apply:

- **Complete the following pages in full**.
  - Incomplete applications may experience delays in processing, so please answer every question.
  - If you're completing this application by hand, please use a pen and write clearly.
- **Submit your application** using one of the following methods:
  - Fill out the online form
  - Email a completed PDF to intake@thelighthousemission.org
  - Fax a completed application t o 360-715-2762
  - Hand deliver to Base Camp at 1312 F St.

After Submitting Your Application

- **Check in weekly by calling 360-733-3796.**
  - You can also check in by sending an email to intake@thelighthousemission.org.
  - This will confirm your ongoing need and keep staff updated with changes to your situation.
  - This keeps your application active - it doesn't guarantee entry into the program.
- **Your application will be reviewed.**
  - This will begin within 5-10 business days after your application is submitted.
  - You may be contacted if we have questions about your application.
  - You may be asked to provide additional information or documentation.
  - Application reviews can take time, especially if we need to contact you for missing information or additional documentation.
- **After your application has been reviewed:**
  - You will be notified whether your application was approved or declined.
  - If your application was declined, we'll refer you to other organizations that might be able to meet your need.
  - If your application was approved, you'll be informed about the next steps.
- **If your application is approved:**
  - You will be contacted for a phone screening and then for an interview.
  - A final approval to enter the program will not take place until after the interview has taken place.
  - You may be added to a waitlist if we don't currently have a bed available.
    - Waitlist times can vary greatly, so we may not be able to give you a good time estimate

Agape Home and Ascent give preference to Whatcom County residents, referrals from local domestic violence agencies, referrals from in-patient treatment facilities, and first-time shelter requests. Agape Home and the Ascent Program are a part of Lighthouse Mission Ministries, a private, non-denominational Evangelical Christian ministry. Some program components may be faith-based, but there are no requirements for program residents to have or make a faith commitment.

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PART 1: BASIC INFORMATION

Name (First): _____ **(Last):** _____ **(Middle)**: _____

Date of Birth: ____/____/____ **Are you a veteran?** ☐ Yes ☐ No ☐ Prefer Not to Answer

Gender: ☐ Man
☐ Woman
☐ Culturally-Specific
☐ Non-Binary
☐ Questioning
☐ Transgender
☐ Different Identity: _____
☐ Don't Know ☐ Prefer Not to Answer

Race: ☐ American Indian/Alaska Native/Indigenous
☐ Asian or Asian American
☐ Black, African American, or African
☐ Hispanic/Latina/e/o
☐ Middle Eastern or North African
☐ Native Hawaiian/Other Pacific Islander
☐ White
☐ Don't Know ☐ Prefer Not to Answer

Primary Language: _____ **Secondary Language:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated ☐ Other: _____

ID/Driver's License Number: _____ **Exp:** _____ **State:** _____

Current City/State/Country of Residence: _____

Best Contact Phone Number: _____ **Voicemail OK?** ☐ Yes ☐ No

Email Address: _____

Emergency Contact: Please list someone you would be comfortable with Lighthouse Mission contacting on your behalf in the event of an emergency.

Name: _____

Phone: _____ **Relationship to You:** _____

Agape Home can accommodate both single women and women with children.

Does your application include residential accommodations for children in your custody? ☐ Yes ☐ No

If YES, complete the last page in this application titled "Information for Children Included in Application."

PART 2: PROGRAM INFORMATION

Our programs were designed to be gender specific. However, we recognize that not everyone identifies as a binary gender. We want to work with you to find the best option for your recovery.

Which program are you applying for? ☐ Agape Home ☐ Ascent Program

What area(s) of focus would you like the program to help you recover from? (e.g. substance use, codependency, other process addictions)

What have you already tried to do to address this problem?

What do you want to accomplish by being in the Ascent/Agape Program? How do you imagine your life a year after entering the program?

Which of the following are areas of concern for you? (Check all that apply)

☐ Marriage	☐ Divorce	☐ Singleness	☐ Work	☐ Grief/Loss
☐ Mental Health	☐ Weight Control	☐ Family Problems	☐ Faith	☐ Intimacy
☐ Self-Esteem	☐ Parenting	☐ Compulsions	☐ Abuse	☐ Housing
☐ Anger Control	☐ Substance Use	☐ Sexual Problems	☐ Identity	☐ Health

Are you willing to work with a case manager to address the above concerns? ☐ Yes ☐ No

We aim for an atmosphere that cultivates trust, personal transformation, and sustainable life change for everyone who enters program services. As such, we want each applicant to be fully aware of what will be required of them upon entry into Agape Home or Ascent.

Agape Home and Ascent are both faith-based programs. Program residents are not required to be Christians or become Christians, but we do believe that attending to the whole person (mind, body, and spirit) is important for a person's long-term recovery. For that reason, all program participants are asked to engage with spiritual practices (e.g. obtaining spiritual supports and community, cultivating practices to meet your spiritual needs, etc.) and are asked to attend church as a part of their regular schedule. Program participants should also expect regular exposure to evangelical Christian practices and beliefs.

Please indicate your willingness for each of the following:

Are you open to the Christ-centered nature of our program?	☐ Yes	☐ No
Are you willing to engage in spiritual practices for yourself?	☐ Yes	☐ No

Below are some of the things we ask of program residents as a part of how we support their recovery.

Please indicate your willingness for each of the following:

Are you willing to not work or hold a job for up to a year?	☐ Yes	☐ No
Do you agree to enter a blackout period (limited external contact) for the first thirty days of your program?	☐ Yes	☐ No
Do you agree to surrender all electronic devices for the first 30 days of your program?	☐ Yes	☐ No
Are you prepared to commit up to 12 months to complete your program?	☐ Yes	☐ No
Do you agree to abstain from entering any new romantic relationships?	☐ Yes	☐ No
Do you agree to turn in all prescription medications upon intake?	☐ Yes	☐ No
Do you agree to attend all classes and participate fully in the program?	☐ Yes	☐ No
Do you agree to participate in work assignments and complete basic daily chores?	☐ Yes	☐ No

PART 3: CURRENT CIRCUMSTANCES

HOUSING

Please indicate your current living situation:

☐ Rented Housing	☐ With Friends/Family	☐ Transitional Housing
☐ Sober Housing	☐ Halfway House	☐ Emergency Shelter
☐ Hospital	☐ In-Patient Treatment Facility	☐ Psychiatric Facility
☐ Jail / Prison	☐ Place Not Meant for Habitation	☐ Emergency Shelter
☐ Hotel / Motel	☐ Other: _____	

Where do you currently reside? City: _____ State/Province: _____

Where was the last place you had stable housing for six months or more?

City: _____ State/Province: _____ Country: _____

Do you have a place you plan to live after your program? ☐ Yes ☐ No ☐ Not Sure

Are you currently active in the Whatcom County housing pool? ☐ Yes ☐ No ☐ Not Sure

TRANSPORTATION

Do you have a current driver's license for Washington State? ☐ Yes ☐ No ☐ Not Sure

If NO, why not?

☐ Revoked/Suspended ☐ Expired ☐ Stolen ☐ I've never been licensed to drive

☐ I'm licensed elsewhere: _____ ☐ Other: _____

Do you currently have a vehicle? ☐ Yes ☐ No

If YES, please provide the following information for your vehicle:

Is your vehicle currently in working condition? ☐ Yes ☐ No ☐ Not Sure

Is your vehicle insured? ☐ Yes ☐ No ☐ Not Sure

Insurer's Name: _____ Policy Number: _____

Is your vehicle registered? ☐ Yes ☐ No ☐ Not Sure

Are the vehicle's tabs current? ☐ Yes ☐ No ☐ Not Sure

Vehicle Make & Model: _____ Year: _____ Color: _____

Do you currently receive paratransit services with WTA? ☐ Yes ☐ No ☐ Not Sure

If NO, are you interested in WTA paratransit services? ☐ Yes ☐ No ☐ Not Sure

Do you have other means of reliable transportation? ☐ Yes ☐ No ☐ Not Sure

If YES, please explain: _____

Please note that while both Ascent and Agape have limited parking options for program residents, for liability reasons all vehicles must be registered, insured, and have current tabs in order to be parked on Mission property. As the driver, the program resident must also have a current license.

EDUCATION

What is your highest level of education?

☐ No Schooling ☐ Grade School ☐ High School/GED ☐ Some College

☐ College Graduate ☐ Graduate School ☐ Other: _____

EMPLOYMENT & FINANCES

Are you currently employed? ☐ Yes ☐ No

If YES, where are you employed? _____

Are you interested in gaining employment after your program? ☐ Yes ☐ No ☐ Not Sure

Do you receive income from any other sources? ☐ Yes ☐ No

If YES, what sources? _____

Do you pay child support? ☐ Yes ☐ No

If YES, how much? _____

Do you pay alimony? ☐ Yes ☐ No

If YES, how much? _____

FAITH / RELIGION

Do you have a current faith or religious affiliation? ☐ Yes ☐ No

If YES, please explain: _____

If NO, are you open to exploring the idea? ☐ Yes ☐ No

Were you raised with a faith or religious affiliation? ☐ Yes ☐ No

If yes, please explain: _____

Do you have past trauma associated with faith / religion? ☐ Yes ☐ No

FAMILY

Please list all members of your immediate family, to include your legal spouse and any children, regardless of whether they're in your custody. If there is insufficient space, please attach an additional sheet.

	Name	Date of Birth	Does this person currently reside with you?	Does your application include this person?
Head of Household				
Spouse				
Child				
Child				
Child				
Child				
Child				

Do you have an open or current case with the Washington Department of Child, Youth, & Family Services (DCYF)? ☐ Yes ☐ No ☐ Not Sure

If YES, are you willing to sign a Release of Information? ☐ Yes ☐ No

LEGAL

We run a criminal background check on all applicants for our residential programs. Please note that any applicant required to register as a sex offender is not eligible for Agape Home. The Ascent Program may be able to provide services to individuals who register as a Level 1 sex offender. Patterns of sexual violence may be subject to a higher level of screening.

Are you a registered sex offender? ☐ Yes ☐ No

If yes, what is your offender level? _____

Are you willing to submit to a criminal background check? ☐ Yes ☐ No

Do you have any pending criminal charges? ☐ Yes ☐ No

Do you have a current protection order against you? ☐ Yes ☐ No

Do you have a protection order against someone else? ☐ Yes ☐ No

Are you currently on probation or under the supervision of the DOC? ☐ Yes ☐ No

Are you a victim of domestic violence? ☐ Yes ☐ No ☐ Not Sure

If YES, how recent was the last occurrence of domestic violence? _____

Are you currently fleeing? ☐ Yes ☐ No ☐ Not Sure

Is there an open case regarding this? ☐ Yes ☐ No ☐ Not Sure

What city and state is your abuser currently in? _____

Please explain any "yes" responses:

PART 4: PERSONAL HISTORY & INFORMATION

SUBSTANCE USE & TREATMENT

Do you currently have a substance use disorder? ☐ Yes ☐ No ☐ Not Sure

What is your substance of choice? (check all that apply)

☐ Alcohol ☐ Marijuana ☐ Meth ☐ Fentanyl ☐ Heroin ☐ Hallucinogens

☐ Cocaine ☐ Inhalants ☐ Benzos ☐ Stimulants ☐ Kratom ☐ Other: _____

Treatment History (Please include any detox facilities. Attach a separate sheet if necessary.)

Outpatient	Inpatient	Facility/City/ State	Treatment Complete?	Date	Length of Stay

Are you currently being treated for a substance use disorder? ☐ Yes ☐ No

Do you currently attend 12-step or other recovery meetings? ☐ Yes ☐ No

If NO, are you willing to attend 12-step or other recovery meetings? ☐ Yes ☐ No

Do you currently have a sponsor? ☐ Yes ☐ No

If NO, are you willing to find a sponsor and work the steps? ☐ Yes ☐ No

NON-TRADITIONAL ADDICTIVE BEHAVIORS

Have you ever struggled with any of the following? (Check all that apply)

☐ Anorexia ☐ Bulimia ☐ Self-Harm ☐ Pornography ☐ Gambling ☐ Unsafe Sex

☐ Overeating ☐ Gaming ☐ Stealing ☐ Overworking ☐ Other: _____

If YES, please explain:

Do you feel you could be addicted to any of the above behaviors? ☐ Yes ☐ No ☐ Not Sure

How many tobacco/nicotine products do you use daily? _____

How many caffeine products do you consume daily? _____

MENTAL & BEHAVIORAL HEALTH

Have you ever been diagnosed with and/or treated for any of the following? (Check all that apply)

☐ Anxiety ☐ Depression ☐ Anger ☐ PTSD ☐ ADHD

☐ Schizophrenia ☐ Borderline Personality Disorder ☐ Dissociative Disorder

☐ Suicide Attempt ☐ Paranoid Personality Disorder ☐ Bipolar Disorder

☐ Autism ☐ Obsessive-Compulsive Disorder ☐ Other: _____

Are you currently receiving mental health services? ☐ Yes ☐ No

Have you ever been admitted to an inpatient facility for any of the above? ☐ Yes ☐ No

Have you ever been placed under an involuntary hold for psychiatric problems? ☐ Yes ☐ No

If YES, please fill out the following:

Date	City/State	Duration of Stay	Name of Hospital

In the last 30 days, have you experienced any of the following? (Check all that apply)

☐ Serious depression ☐ Thoughts of suicide ☐ Suicide attempts

☐ Serious anxiety ☐ Panic attack ☐ Hallucinations

☐ Dissociative episode ☐ Trouble controlling temper ☐ Thoughts of hurting someone

☐ Emotional abuse ☐ Physical abuse ☐ Sexual abuse / Survival sex work

MEDICAL INFORMATION

Do you currently have medical insurance? ☐ Yes ☐ No

If NO, are you willing to secure and maintain medical insurance? ☐ Yes ☐ No

If YES, who is your insurance provided through? _____

Do you have any physical or developmental disabilities? ☐ Yes ☐ No

If YES, please explain:

Please list any medical diagnosis you currently have:

When did you last have a physical and/or full medical exam?

_____

Do you currently have a primary care doctor? ☐ Yes ☐ No

Are you currently seeing a specialist for any medical needs? ☐ Yes ☐ No

If YES, please explain:

PART 5: CURRENT PROVIDERS & CASE MANAGERS

Please provide information on all your current providers and case managers. This information is important for our staff to coordinate your care and ensure the services we provide to you don't conflict with work your other providers are doing on your behalf.

Primary Care ☐ I don't have a provider for this

Provider Name: _____ Phone Number: _____

Network//Agency: _____

Address: _____

Are you willing to sign a Release of Information? ☐ Yes ☐ No

Medical Specialist ☐ I don't have a provider for this

Provider Name**:** _____ Phone Number: _____

Network/Agency: _____

Address**:** _____

Are you willing to sign a Release of Information? ☐ Yes ☐ No

Dental ☐ I don't have a provider for this

Provider Name**:** _____ Phone Number: _____

Network/Agency: _____

Address**:** _____

Are you willing to sign a Release of Information? ☐ Yes ☐ No

Mental / Behavioral Health ☐ I don't have a provider for this

Provider Name**:** _____ Phone Number: _____

Organization/Agency: _____

Address**:** _____

Are you willing to sign a Release of Information? ☐ Yes ☐ No

Substance Use ☐ I don't have a provider for this

Provider Name: _____ Phone Number: _____

Organization/Agency: _____

Address: _____

Are you willing to sign a Release of Information? ☐ Yes ☐ No

Housing Case Manager ☐ I don't have a case manager for this

Case Manager Name: _____ Phone Number: _____

Organization/Agency: _____

Address: _____

Are you willing to sign a Release of Information? ☐ Yes ☐ No

DCYF Case Manager ☐ I don't have a case manager for this

Case Manager Name: _____ Phone Number: _____

Address: _____

Are you willing to sign a Release of Information? ☐ Yes ☐ No

Probation Officer ☐ I don't have a probation officer

Officer Name: _____ Phone Number: _____

Organization/Agency: _____

Address: _____

Are you willing to sign a Release of Information? ☐ Yes ☐ No

Other Provider ☐ I don't have any other providers

Provider Name: _____ Phone Number: _____

Organization/Agency: _____

Address: _____

Are you willing to sign a Release of Information? ☐ Yes ☐ No

PART 6: MEDICATION LIST

Please list all your current medications in the space provided below. Attach additional sheets if necessary. Please include ALL medication names, as medical documentation is a required part of screening. Failure to list all medications may delay the screening process.

Medication Name: ______________________ Dose: ______________________

How long have you been taking this medication? ______________________

What is this medication prescribed for? ______________________

Is this medication effective? ☐ Yes ☐ No

Medication Name: ______________________ Dose: ______________________

How long have you been taking this medication? ______________________

What is this medication prescribed for? ______________________

Is this medication effective? ☐ Yes ☐ No

Medication Name: ______________________ Dose: ______________________

How long have you been taking this medication? ______________________

What is this medication prescribed for? ______________________

Is this medication effective? ☐ Yes ☐ No

Medication Name: ______________________ Dose: ______________________

How long have you been taking this medication? ______________________

What is this medication prescribed for? ______________________

Is this medication effective? ☐ Yes ☐ No

Medication Name: ______________________ Dose: ______________________

How long have you been taking this medication? ______________________

What is this medication prescribed for? ______________________

Is this medication effective? ☐ Yes ☐ No

Medication Name: _____ Dose: _____

How long have you been taking this medication? _____

What is this medication prescribed for? _____

Is this medication effective? ☐ Yes ☐ No

Medication Name: _____ Dose: _____

How long have you been taking this medication? _____

What is this medication prescribed for? _____

Is this medication effective? ☐ Yes ☐ No

Medication Name: _____ Dose: _____

How long have you been taking this medication? _____

What is this medication prescribed for? _____

Is this medication effective? ☐ Yes ☐ No

Medication Name: _____ Dose: _____

How long have you been taking this medication? _____

What is this medication prescribed for? _____

Is this medication effective? ☐ Yes ☐ No

Medication Name: _____ Dose: _____

How long have you been taking this medication? _____

What is this medication prescribed for? _____

Is this medication effective? ☐ Yes ☐ No

PART 7: APPLICANT UNDERSTANDING & SIGNATURE

Please take the time to thoroughly review your application prior to submitting it to check for accuracy and completeness.

Is there any information we should know that isn't covered in this application?

I declare that the information provided in this application is true and correct, to the best of my knowledge. I understand that intentionally providing false information may impact my eligibility to receive services in the program I'm applying for. I understand that submission of this application is not a guarantee of entry into the program. I understand that if my situation or the information I provided in this application changes, it is my responsibility to provide updated information when I make my weekly check-in.

Applicant Signature: _____ **Date:** _____

Office Use Only

Date Application Received: _____ Received By: _____

INFORMATION FOR CHILDREN INCLUDED IN APPLICATION

Please fill out this page if you are applying for Agape Home AND you have children under the age of 18 in your custody who you intend to have live with you at Agape Home. Please complete a separate copy of this page for every child included in your application.

Child's Name (First): _____ (**Last):** _____ **(Middle)**: _____

Name Child Goes By: _____ **Date of Birth:** ____/____/____

Gender:
- ☐ Man/Boy
- ☐ Woman/Girl
- ☐ Culturally-Specific
- ☐ Non-Binary
- ☐ Questioning
- ☐ Transgender
- ☐ Different Identity: _____
- ☐ Don't Know ☐ Prefer Not to Answer

Race:
- ☐ American Indian/Alaska Native/Indigenous
- ☐ Asian or Asian American
- ☐ Black, African American, or African
- ☐ Hispanic/Latina/e/o
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Don't Know ☐ Prefer Not to Answer

Is your child currently enrolled in school? ☐ Yes ☐ No

If YES, what school? _____

Does your child receive childcare services? ☐ Yes ☐ No

If YES, where? _____

Does your child currently have a primary care provider? ☐ Yes ☐ No

Does your child currently have any medical conditions? ☐ Yes ☐ No

If YES, please explain: _____

Does your child have any mental health conditions? ☐ Yes ☐ No

If YES, please explain: _____

Please list all medications this child takes: _____

Does your child have any developmental disabilities or delays? ☐ Yes ☐ No

If YES, please explain: _____

Is this child involved in an open CPS case? ☐ Yes ☐ No

Is it possible this child may have suffered abuse at the hands of another? ☐ Yes ☐ No

If YES, please explain: _____

Are you interested in gaining additional services for this child? ☐ Yes ☐ No