

## *Teen Challenge Philadelphia Women's Admissions Requirements*

Intake Supervisor: Gerri Hubbard

**Phone:** (215) 843-2887 or (215) 844-2763; **Fax:** women (215) 843-3595 or men (215) 843-6430

### **Entrance Requirements**

**BEFORE ENTRANCE INTO THE TEEN CHALLENGE PROGRAM, THERE ARE SEVERAL THINGS THAT ARE REQUIRED.**

1. All medical results must be sent to Teen Challenge.
2. All fees' must be sent to Teen Challenge.
3. All I.D. must be sent to Teen Challenge

The afore-mentioned are required to be in my office before a bed date will be given. Please send the above to:

Intake Supervisor  
c/o Teen Challenge Philadelphia  
329 E. Wister Street  
Philadelphia, PA 19144

**Please follow these instructions closely:**

1. **Entrance fee is \$750. Money Order** must be made out to "**Teen Challenge**", (once you enter the program, the \$750 is non-refundable). You must also send in return fare home. **Return fare** is the amount of money that it would cost you to get home by bus, train, or plane (preferably by bus). Please **do not buy a round trip ticket**. Return fare should be in a separate **money order** made payable to **you**.
2. In order to enter the Teen Challenge program, you must have the following I.D.'s:
  - a. Social Security Card
  - b. Picture I.D.
  - c. Birth Certificate
3. If you are on S.S.I., or receive a monthly check, you will be required to pay a monthly housing allowance to Teen Challenge (\$310.00 + food allowance).
4. You must call me every Tuesday to check-in. This is part of the entry procedure. I cannot make long distance calls; therefore if I don't hear from you, I will conclude you are not interested in continuing with the entry process. This could result in the loss of a bed date.
5. Please bring in clothing, toiletries that do not contain alcohol and personal items. You will not be allowed more than two (2) suitcases. You need some sort of laundry bag (a pillowcase will be OK). Please do not bring any tight fitting or low cut tops. The length of dresses and skirts must be at least down to the knee or longer. Shorts must come to the knees. You will not need towels, pillows, blankets and sheets. We will provide them for you.

6. Teen Challenge Philadelphia is not a dual-diagnosed program therefore clients in the program are not permitted to take any type of psychotropic medications. This includes anti-depressants, anti-anxiety medications, anti-psychotics and other similar-type acting medications. If you are currently on these types of medications your physician must give you permission, a weaning schedule and enough medication to be weaned off safely when you come into the program. (Clients are also not allowed to take any kind of narcotic/opiate/addictive pain medications while in the program.)
7. You will need a letter from your last employer(s) on **company letterhead** stating your earnings and dates of employment, also stating if and why you were terminated. If you are on probation/parole you will need a letter from your PO **on their letterhead** stating how long you are on probation/parole. You will need a letter from whoever has supported you during the past year if you have not been employed. The afore-mentioned is required should you qualify for welfare. This must also be sent to me before entrance into the program.
8. **Unless you live in Philadelphia, all welfare cases, including medical, must be closed before entering the program.**
9. If you live out of the state, you will not get medical or dental care. Please have all dental needs taken care of prior to admission. Also, if you are on medication, make sure you bring at least two (2) months supply with you.
10. Please do not bring any books with you except for an NIV Bible, which you will need for your class work. You may bring a total of five (5) music cassettes. They must be originals and be "Praise and Worship" type music. Approved brands of "Praise and Worship" are: INTEGRITY, HOSANNA, MARANATHA, VINEYARD, and CELTIC PRAISE AND WORSHIP.
11. During your stay in the program, we will charge a \$.42 per mile fee to your personal account for any appointments (court, doctor, dentist, etc.) that require the use of a Teen Challenge vehicle.

\*\*\*\*Thank You for your cooperation in these areas\*\*\*\*

**Philadelphia Teen Challenge Women's Home  
MEDICAL HISTORY and PHYSICAL EXAMINATION FORM**

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Induction Center: Philadelphia Teen Challenge  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

1. The following lab work is required for admission to the program and copies must be sent in prior to entrance:
  - A. RPR – Reactive or Non-reactive (*circle one*) \_\_\_\_\_ (date read)
  - B. Liver Function Tests \_\_\_\_\_ (date read)
  - C. Hepatitis Screening, if indicated, based on history or abnormal liver function test results  
Circle pos. or neg. for each: **Hepatitis A** – pos. or neg.; **Hepatitis B** – pos. or neg.; **Hepatitis C** – pos. or neg.
  - D. CBC \_\_\_\_\_
  - E. Pregnancy test and PAP smear \_\_\_\_\_
2. T.B. testing is MANDATORY and results included should be no older than 6 months prior to admission to induction center. Chest X-ray is required if the TB test comes out positive. Tetanus shots must be up-to-date with documentation of date given.

|                            |   |
|----------------------------|---|
| <b>Tuberculin Test/PPD</b> | Date ____/____/____ Size _____<br>Chest X-ray _____ |
| <b>Tetanus toxoid</b>      | Date ____/____/____                                 |

3. Immunizations should be up-to-date and include:
  1. Measles date performed \_\_\_\_\_
  2. Mumps date performed \_\_\_\_\_
  3. Rubella date performed \_\_\_\_\_

**Has HIV testing been performed? Yes \_\_\_ No \_\_\_** **\*\*enclose reports pertaining to HIV results along with signed consent for release of information.**

**4. Significant Medical Conditions (√):**

|                           | Yes                      | No                       | If Yes, Explain |
|---------------------------|--------------------------|--------------------------|-----------------|
| Asthma                    |                          |                          |                 |
| Cardiac                   |                          |                          |                 |
| Chemical Dependence       | <input type="checkbox"/> | <input type="checkbox"/> |                 |
| Drugs:                    | <input type="checkbox"/> | <input type="checkbox"/> |                 |
| Alcohol:                  | <input type="checkbox"/> | <input type="checkbox"/> |                 |
| Diabetes Mellitus         |                          |                          |                 |
| Gastrointestinal Disorder |                          |                          |                 |
| Hearing Disorder          |                          |                          |                 |
| Hypertension              |                          |                          |                 |
| Neuromuscular Disorder    |                          |                          |                 |
| Orthopedic Condition      |                          |                          |                 |
| Respiratory Illness       |                          |                          |                 |
| Seizure Disorder          |                          |                          |                 |
| Skin Disorder             |                          |                          |                 |
| Vision Disorder           |                          |                          |                 |
| Other (Specify)           |                          |                          |                 |

5. Current/routine medications:

| MEDICATION | DOSAGE |
|------------|--------|
| 1.         |        |
| 2.         |        |
| 3.         |        |
| 4.         |        |

6. Please list any allergies you have to any medications, foods, or other substances: \_\_\_\_\_  
 \_\_\_\_\_

7. **Report of Physical Examination (√)**

| Normal | Abnormal | if Abnormal, Please explain |
|--------|----------|-----------------------------|
|--------|----------|-----------------------------|

|  |  |  |  |
|--|--|--|--|
| • Height (inches)                              |  |  |  |
| • Weight (pounds)                              |  |  |  |
| • Temperature                                  |  |  |  |
| • Pulse ( )                                    |  |  |  |
| • Blood Pressure                               |  |  |  |
| • Hair/Scalp                                   |  |  |  |
| • Skin   |  |  |  |
| • Eyes - Visual Acuity R ___ / ___ L ___ / ___ |  |  |  |
| • Eyes - Color Vision                          |  |  |  |
| • Ears - Hearing dB R L                        |  |  |  |
| • Nose and Throat                              |  |  |  |
| • Teeth and Gingiva                            |  |  |  |
| • Lymph Glands                                 |  |  |  |
| • Heart – Murmur, ETC.                         |  |  |  |
| • Lung - Adventitious Findings                 |  |  |  |
| • Abdomen                                      |  |  |  |
| • Genitalia                                    |  |  |  |
| • Neuromuscular System                         |  |  |  |
| • Extremities                                  |  |  |  |
| • Spine (Presence of Scoliosis)                |  |  |  |

**Must be completed**

8. \*Physician's observations and comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
**Name of Examiner ( please print )**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Signature of Physician**

\_\_\_\_\_  
**Date of Examination**

TO ALL PHYSICIANS:

PLEASE MAKE SURE EACH FIELD ON PHYSICAL IS FILLED IN. FOR QUESTION #8, PHYSICIAN MUST STATE CLIENT'S APPEARANCE (WHAT CLIENT LOOKS LIKE TO THEM).

**EXAMPLE:** PLEASE FILL OUT AS SHOWN BELOW

Must be completed

9. \*Physician's observations and comments:  
neatly dressed, alert, appropriate for program, appears healthy, cooperative & pleasant.  
\_\_\_(Example: she is well dressed and appropriate for the program)

\_\_\_\_ ( Put you're name, and state who you are on the appropriate line below. Please print so we can read it as it is shown)

\_\_\_\_\_  
Name of Examiner ( please print )

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date of Examination

(all these things need to be done on item number 8)

**Form will be UNACCEPTABLE if examiner's title and address are ILLEGIBLE.**

**Teen Challenge Philadelphia \* 329 E. Wister St. \* Philadelphia, Pa. 19144**

**Remember:**

- FOR ITEM #4 IF REPLY IS YES AN EXPLANATION IS REQUIRED TO THE RIGHT OF REPLY
- FOR ITEM #7 IF REPLY IS ABNORMAL AN EXPLANATION IS REQUIRED TO THE RIGHT OF REPLY