

Application Questionnaire – SVABW EAP Program

Name (First, Middle I., Last): _____

Address: _____

City/State/Zip: _____

Home Telephone: _____

Work Telephone: _____

Mobile Telephone: _____

Marital Status (check one): Single Married Separated Divorced

Number of Children: Ages of Children: _____

Are you able to arrange child care for four Saturdays in May 2010 (5/8,15,22,29)? Yes No

If No, I will require childcare for children, ages: _____
(how many)

Have you experienced physical violence in a recent (within 3 yrs) intimate relationship? Yes No

If Yes, approximately how often did incidents occur? Daily Weekly Monthly Other

Did you suffer injuries that required medical attention? Yes No

Have you experienced physical violence in past intimate relationships? Yes No

If Yes, approximately how many? _____

Were there incidents of physical violence in your family as a child? Yes No

Are you able to commit to attending four, four-hour sessions on consecutive Saturdays in May 2010 (5/8,15,22,29)? Yes No

Do you have transportation available? Yes No

Are you currently (or recently) under the care of a mental health professional? Yes No

Are you currently taking any medications that might impair your ability to react quickly? Yes No

If Yes, please explain: _____

Please explain why you're interested in participating in a program for domestic violence survivors:

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Do you currently have an Order for Protection against your partner? Yes ___ No ___

If Yes, has your partner violated any of the OFP requirements? Yes ___ No ___

If Yes, please explain: _____

Are you currently employed? Yes ___ No ___

Do you have any physical or cognitive disabilities that would prevent you from responding quickly to directions that may require speed of movement? Yes ___ No ___

If Yes, please explain: _____

Participation in this program requires participants to be drug and alcohol free during all sessions. This is for the safety of all participants and violators will be dismissed and not allowed to return if confirmed to be under the influence of drugs or alcohol during the program.

By signing below I, _____, agree that I have read and answered the
(PRINT NAME)

above questions truthfully and understand the program requirements.

Signature

Date

Please fax or mail completed form to:

Southern Valley Alliance
P.O. Box 166
Belle Plaine, MN 56011
952-873-4214
FAX: 952-873-4673