

CherishedLA

Residential Application

Please don't hesitate to contact us with questions! Applications may be submitted by mail, email, or in-person. We will follow up to schedule an intake phone call.

661.214.3020

cherishedla@gmail.com

Address [For mailing only – for security, our location is not public.]:

2010 W Ave K #448

Lancaster, CA 93536

What We Do

SUPPORT GROUP

We invite women survivors of human trafficking and the commercial sex industry to join us every Friday morning from 10 a.m. to 12 p.m. for breakfast and support group. Our support groups are a safe place to talk for survivors, including those who currently work in the sex industry.

RESIDENTIAL PROGRAM

We provide free housing through our residential program. Residents learn how to live in a safe community and participate in a comprehensive recovery program, including therapy groups, life skills classes, fun activities, and more. We encourage all residents to complete or continue their education and work towards their own goals for their future. We offer a 90-day transitional program with the option to continue onto our full 2-year recovery program.

EMPLOYMENT

After completing job skills training, Cherished residents are eligible to work in the Cherished Studio where our artisans make handcrafted jewelry, including an exclusive line that is sold in an international fair-trade catalog. Cherished artisans also handcraft all-natural bath and body products, soy wax candles, and seasonal items. Residents at Cherished learn skills valuable for future employment such as punctuality, teamwork, communication, perseverance, and self-motivation.

OUTREACH

Our outreach team visits local strip clubs and massage parlors to give small gifts to the women who work there and invite them to support group. Our founder, Kate, worked in strip clubs and the commercial sex industry for 10 years. Kate recalls that there were many nights she would have left the industry if someone had offered her a chance. We want all women to know that they are loved, valued, and Cherished.

Application for CherishedLA

Please complete this application in your own words. *This information is confidential.* If you would like us to share information with anyone, you may complete a Release of Information allowing us to communicate with them (the form is attached to the end of this application).

Name: _____ Date: _____

Preferred Name: _____ Social Security #: _____

Current City: _____ State: _____ Zip: _____

Primary Phone #: (_____) _____ Secondary Phone #: (_____) _____

E-mail: _____

Date of Birth: _____ Age: _____

Are you a U.S. citizen (does not affect program eligibility)?

Yes No (please list status) _____

Birthplace (city, state, country): _____

Ethnicity: African American Asian Caucasian Hispanic Native American Other

Have you applied to CherishedLA before? Yes No When? _____

Have you been a resident at CherishedLA? Yes No When? _____

Referring Agency Information

How did you hear about CherishedLA? _____

With your permission, we will keep the referring agency you list updated on your application process. Please fill out the Release of Information form at the end of this application if you would like us to be in contact with the referring agency you list.

Name: _____ Agency: _____

Phone: _____ Email: _____

Marital Status: Single Engaged Married Separated Divorced

Describe any relevant information: _____

Children

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Who has custody of your children? _____

What arrangements are being made for your children while you are at CherishedLA?

Will being at CherishedLA have any effect on your custody status? Yes No

If yes, explain: _____

Social Worker Name: _____ Phone: _____

What are your visitation rights? _____

Are you willing to have CherishedLA staff monitor visitations? Yes No

Pregnancy

Are you pregnant? Yes No

If yes, give approximate due date: _____

Has a doctor confirmed your pregnancy? Yes No

Medical

Do you have any allergies? Yes No Do you require an EpiPen? Yes No

List all allergies (food, medicine, animal): _____

List all medication and supplements that you take:

Medication/Supplement	Dosage	Reason	For How Long

Are any of your medications court appointed? Yes No

If you have been prescribed medications, please continue to take them as prescribed. If possible, bring a 30-day supply of any current medications.

List any dietary restrictions/limitations: _____

Were these restrictions/limitations recommended by a doctor? Yes No

Do you have, or have you ever had, a problem with food or eating? Yes No

If yes, explain: _____

Have you been diagnosed with or treated for an eating disorder? Yes No

Doctor's Name: _____ Phone: (_____) _____

List any physical limitations and/or medical conditions (asthma, migraines, thyroid, diabetes, blood pressure, heart problems, etc.) that you may have:

List all past surgeries or hospitalizations (include dates/reasons for hospital stays):

Legal Background

Have you been arrested for any of the following (select all that apply)?

Prostitution Pimping/Pandering Possession/Sale of Drugs

Other: _____ How many times? _____

Please list dates, charges, etc.:

Do you have any pending court dates? Yes No

Please provide details: _____

Are you currently incarcerated? Yes No How long? _____ Time left? _____

Legal Representative: _____ Phone #: (_____) _____

Are you currently on: Probation? Yes No Parole? Yes No

If so, how long? _____ Length of time remaining: _____

Substance Use – Check any substances you have experimented with.

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Crystal Meth | <input type="checkbox"/> Meth |
| <input type="checkbox"/> Amphetamines (uppers) | <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Barbiturates (downers) | <input type="checkbox"/> Hallucinogenic (Acid, LSD, etc.) | <input type="checkbox"/> Opium |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Heroin | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Crack | <input type="checkbox"/> Inhalants (Glue, Paint Thinner, etc.) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Crank | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Other: _____ |

Drug of Choice:

1. _____ Length of Use _____ Date Last Used _____

2. _____ Length of Use _____ Date Last Used _____

Counseling and Treatment

Have you ever been diagnosed or treated for (check all that apply):

- ADD/ADHD
- Anxiety
- Asperger's Syndrome
- Bi-Polar Disorder
- Borderline Personality Disorder
- Depression
- Dissociative Identity Disorder
- Obsessive Compulsive Disorder
- Oppositional Defiant Disorder
- Post-Traumatic Stress Disorder
- Reactive Attachment Disorder
- Schizoaffective Disorder
- Schizophrenia
- Other: _____

Have you ever dissociated (a state of involuntary separation from reality caused by stress or trauma)?

- Yes No If yes, briefly explain: _____

Have you been in any in/outpatient counseling in the last 2 years? Yes No

Please list any type of care you have received within the last 2-3 years that fall within these general categories: psychiatrist care, psychiatric hospital, counseling/therapy, rehabilitation center of any kind, dietitian oversight, substance use program, etc.

Entry Date	Name	City, State	Reason for Leaving	Discharge Date

Personal History

Have you ever tried to commit suicide? Yes No

When? _____ How? _____ Why? _____

Have you ever self-harmed? Yes No How? _____

At what age did you start? _____ Is this a current struggle? _____

Have you ever required medical treatment for self-harm? Yes No

Have you been sexually exploited? Yes No

Which of the following have you experienced? (select all that apply)

Prostitution Stripping Escort Service Phone Sex

Trading Sex for Money, Drugs, Gifts, or Survival Needs

Tell us a brief description of being sexually trafficked or in the sex industry:

Current Situation

What are your current living arrangements?

Pimp Family Member Alone Friends

Car Hotel Shelter/Facility: _____

Are you on government or financial assistance? Yes No

Will your coming to CherishedLA have any effect on this assistance? Yes No

Will anyone be able to assist you with personal/medical financial needs while at CherishedLA (church, ministry, family or individual)? If yes, who?

What does healing and recovery look like for you?

Safe Contact List:

These are people that will be supportive of your recovery that you would like to be able to contact while you are in the program.

1 Safe Person (Phase 1)

Name: _____ Relation: _____

Phone: _____

4 Safe People (Phase 2)

Name: _____ Relation: _____

Phone: _____

Name: _____ Relation: _____

Phone: _____

Name: _____ Relation: _____

Phone: _____

Name: _____ Relation: _____

Phone: _____

DECLARATION

By signing below, I am indicating that the info I have provided is truthful to the best of my knowledge and I have not knowingly withheld information.

Signature: _____

Print Name: _____

Date: _____

RELEASE OF INFORMATION FORM

All matters relating to applicant records and information are considered confidential and are treated as such by the staff of CherishedLA. Information regarding such matters cannot be given without the written consent of the applicant.

Name of Applicant: _____ DOB: _____

I, _____, do hereby give permission for CherishedLA to share information related to my application to the program with:

(For example, you may want to include family members, pastors, mentors etc.)

1. _____
2. _____
3. _____
4. _____

I also give the following professionals, programs/facilities, and other staff permission to exchange information with CherishedLA for the purpose of my application:

1. _____
2. _____
3. _____
4. _____

This release will expire on (date) _____ unless written notification by the applicant indicates otherwise. (If blank, release expires in 2 years.)

Signature of Applicant

Date