

NEHEMIAH PROJECT

Application

Thank you for taking the time to complete this application. We realize this is a lengthy application, but we feel it will help us to best understand your current situation. This information will assist us in helping you achieve a healthy balance in your personal and spiritual lives.

This application is divided in two major sections; one section for the applicant (person requesting assistance) and one for the spouse (if applicable). Within each major section are four subsections with questions relating to personal, spiritual, financial and relational aspects of your life. While we encourage you to assist each other in completing the sections, it is important that each adult complete this form individually to gain the best picture of your current health state.

Page 1 through 5 - to be filled out by one adult (applicant)

Pages 6 through 9 – to be filled out by the spouse of applicant (if applicable)

SECTION A – PERSONAL (APPLICANT)				
First Name	Middle Name	Last Name		
Current Address	City	State	Zip	How long?
Previous Address	City	State	Zip	How long?
Home Phone Number	Work Phone Number	Cell Phone Number		
Date of Birth (dd/mm/yyyy)	Marital Status (mark all that currently apply) <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married How long (yrs/mos) _____ <input type="checkbox"/> Divorced How long (yrs/mos) _____ How many times _____			
General Health				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Body Weight	Height	
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a primary care physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last visit to primary care physician		
Do you have a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many times a year do you visit the dentist?			
Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes - # packs per day:	Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes - # drinks per week:	How many hours of sleep do you get per night on average? Do you feel rested?		
Do you exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes – how often:	How many meals and/or snacks do you consume per day?	Do you eat dinner together as a family regularly? How often?		
How would you describe a “healthy lifestyle”?				
In general, would you say your health is: <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor				
Compared to one year ago, how would you rate your health in general now? <input type="checkbox"/> Much better now than one year ago <input type="checkbox"/> Somewhat better now than one year ago <input type="checkbox"/> About the same <input type="checkbox"/> Somewhat worse now than one year ago <input type="checkbox"/> Much worse than one year ago				

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Physical health problems: During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
Cut down the amount of time you spent on work or other activities <input type="checkbox"/> Yes <input type="checkbox"/> No
Accomplished less than you would like <input type="checkbox"/> Yes <input type="checkbox"/> No
Were limited in the kind of work or other activities <input type="checkbox"/> Yes <input type="checkbox"/> No
Had difficulty performing the work or other activities (for example, it took extra effort) <input type="checkbox"/> Yes <input type="checkbox"/> No
Emotional health problems: During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
Cut down the amount of time you spent on work or other activities <input type="checkbox"/> Yes <input type="checkbox"/> No
Accomplished less than you would like <input type="checkbox"/> Yes <input type="checkbox"/> No
Didn't do work or other activities as carefully as usual <input type="checkbox"/> Yes <input type="checkbox"/> No
Social activities:
Emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? <input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe
Pain:
How much bodily pain have you had during the past 4 weeks? <input type="checkbox"/> None <input type="checkbox"/> Very mild <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe
During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? <input type="checkbox"/> Not at all <input type="checkbox"/> A little bit <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely
General health: How true or false is each of the following statements for you?
I seem to get sick a little easier than other people <input type="checkbox"/> Definitely true <input type="checkbox"/> Mostly true <input type="checkbox"/> Don't know <input type="checkbox"/> Mostly false <input type="checkbox"/> Definitely false
I am as healthy as anybody I know <input type="checkbox"/> Definitely true <input type="checkbox"/> Mostly true <input type="checkbox"/> Don't know <input type="checkbox"/> Mostly false <input type="checkbox"/> Definitely false
I expect my health to get worse <input type="checkbox"/> Definitely true <input type="checkbox"/> Mostly true <input type="checkbox"/> Don't know <input type="checkbox"/> Mostly false <input type="checkbox"/> Definitely false
My health is excellent <input type="checkbox"/> Definitely true <input type="checkbox"/> Mostly true <input type="checkbox"/> Don't know <input type="checkbox"/> Mostly false <input type="checkbox"/> Definitely false

CHILDREN			
Child 1			
First Name	Middle Name	Last Name	
Date of Birth (dd/mm/yyyy)	School Attending	What grade/year	
Percent of time living with you %	Where does this child live when not with you?		
Child 2			
First Name	Middle Name	Last Name	
Date of Birth (dd/mm/yyyy)	School Attending	What grade/year	
Percent of time living with you %	Where does this child live when not with you?		

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Child 3		
First Name	Middle Name	Last Name
Date of Birth (dd/mm/yyyy)	School Attending	What grade/year
Percent of time living with you %	Where does this child live when not with you?	
Child 4		
First Name	Middle Name	Last Name
Date of Birth (dd/mm/yyyy)	School Attending	What grade/year
Percent of time living with you %	Where does this child live when not with you?	

SECTION B – SPIRITUAL (APPLICANT)		
How often do you attend church?	How long have you been attending FCC?	Does your entire family attend church together?
Have you been baptized by immersion?	Date of immersion	
Do you read Scripture regularly/how often?	Do you have a prayer dedication time? Please explain.	
Do you attend Adult Bible Study Class?	What is your favorite Bible verse?	
Do you serve at FCC?	If so, where/how do you serve?	
What other groups/programs are you involved in at FCC?		
Are you involved in religious studies/groups outside of FCC? If so, what?		
I feel most connected to God when I am:		

SECTION C – FINANCIAL (APPLICANT)		
Employment		
Current Employer	Current Employer Address	
Job Title	Dates Employed	Income (year/month/week)
List all Current Benefits		
Previous Employer	Previous Employer Address	
Job Title	Dates Employed	Income (year/month/week)

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Other sources of income (please list what type of income and amount paid)	
Income Source	Pay (year/month/week)
Income Source	Pay (year/month/week)
Income Source	Pay (year/month/week)

Expenses			
Monthly Mortgage Payment: <input type="checkbox"/> Current <input type="checkbox"/> Currently Behind	\$	Credit Card Debt <input type="checkbox"/> Current <input type="checkbox"/> Currently Behind	\$
Monthly Car Payment: <input type="checkbox"/> Current <input type="checkbox"/> Currently Behind	\$	School Debt <input type="checkbox"/> Current <input type="checkbox"/> Currently Behind	\$
Healthcare Debt <input type="checkbox"/> Current <input type="checkbox"/> Currently Behind	\$	Other Debt (explain) <input type="checkbox"/> Current <input type="checkbox"/> Currently Behind	\$
Do you give money to any charitable organizations? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much? (list all charities individually)		\$
Are you giving money to anyone, such as a family member? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much? (list all individually)		\$
Do you tithe? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much do you give to the church?		\$
Annual Household Income	\$	Filed Bankruptcy in the past 7 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If married, do you and your spouse have separate or joint accounts?			Who pays the bills in your family?
Do you create a monthly budget? If not, why?			
Are you documenting your expenses?		Do you balance your checkbook?	

SECTION D – RELATIONAL (APPLICANT)

All marriages have strengths as well as weaknesses and we’re all, in a sense, blending two separate families together when we speak of marriage with important histories, cultural differences, and preferences. These following statements are in no way exhaustive of all aspects of marriage relationships and are only to help provide you with feedback on how you may be functioning relationally, which impacts how you are being built up for God: There may be opportunities for you to discuss things more so that you grow in your intimacy as well as in your relationship with God, find more meaningful activity in your marriage, and even celebrate what is already going well! If you find that any items concern you, please don’t hesitate to address them with us, people you trust, pastoral care, or with some form of qualified counsel before they become more complicated. Remember, **all** married people benefit from growth at some level and no one is immune to trials however they may come!

For all of the following items, please **circle** one of the following:

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Strengths and Weaknesses					
1. When my spouse has an idea, it's the right one or the one we will likely select.	Not at All	Seldom	Sometimes	Mostly	Always
2. I can express clearly to my spouse what I'm thinking and feeling as the situation arises.	Not at All	Seldom	Sometimes	Mostly	Always
3. I look forward to seeing my spouse when I come home or when my spouse arrives at home.	Not at All	Seldom	Sometimes	Mostly	Always
4. I know whatever may be bothering my spouse on any given day.	Not at All	Seldom	Sometimes	Mostly	Always
5. When we have conflicts in our marriage, usually someone wins.	Not at All	Seldom	Sometimes	Mostly	Always
6. God would smile upon our sexual intimacy, since He designed marriage, anyway, and sees all things.	Not at All	Seldom	Sometimes	Mostly	Always
7. I know by clear evidence that my spouse listens when I speak.	Not at All	Seldom	Sometimes	Mostly	Always
8. We are able to limit difficult conversations to mutually agreed-upon time-frames and in ways that do not ambush one another.	Not at All	Seldom	Sometimes	Mostly	Always
9. I feel that I am validated and valued in our marriage.	Not at All	Seldom	Sometimes	Mostly	Always
10. When I have an idea in my mind while my spouse is speaking I might interrupt so I can get my points across or else I fear I will lose my idea.	Not at All	Seldom	Sometimes	Mostly	Always
11. We laugh an awful lot together.	Not at All	Seldom	Sometimes	Mostly	Always
12. I am often accused of not hearing what my spouse is saying even when I think I have fully participated.	Not at All	Seldom	Sometimes	Mostly	Always
13. My way is the highway; my opinion is usually the one that carries the weight in all matters.	Not at All	Seldom	Sometimes	Mostly	Always
14. Talking through difficult issues in our marriage usually opens wounds...we avoid discussing them.	Not at All	Seldom	Sometimes	Mostly	Always
15. My spouse is a growing man/woman of Christ and I know his/her fruit to be evident of this.	Not at All	Seldom	Sometimes	Mostly	Always
16. When we have disagreements, we are able to come back to each other with dignity.	Not at All	Seldom	Sometimes	Mostly	Always
On a scale of 1 to 10, what is your relationship with your father/mother? (1=distant/rarely speak to, 10=speak to/see regularly)	Do you feel your parents taught you what you needed to know to function as an adult?				

Everything provided is to the best of my knowledge. I understand that my next step is to be contacted by a Nehemiah Project Team member to discuss the application information.

Applicant's Signature

Date

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This application is divided in two major sections; one section for the applicant (person requesting assistance) and one for the spouse (if applicable). Within each major section are four subsections with questions relating to personal, spiritual, financial and relational aspects of your life. While we encourage you to assist each other in completing the sections, it is important that each adult complete this form individually to gain the best picture of your current health state.

Page 1 through 5 - to be filled out by one adult (applicant)

Pages 6 through 9 – to be filled out by the spouse of applicant (if applicable)

SECTION A – PERSONAL (SPOUSE)							
First Name		Middle Name		Last Name			
Current Address		City		State	Zip		
Previous Address		Previous City		Previous State	Previous Zip		
Home Phone Number		Work Phone Number		Cell Phone Number			
Date of Birth (dd/mm/yyyy)		Marital Status (mark all that currently apply)					
		<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married How long (yrs/mos) _____ <input type="checkbox"/> Divorced How long (yrs/mos) _____ How many times _____					
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Age		Body Weight		Height	
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have a primary care physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of last visit to primary care physician			
Do you have a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many times a year do you visit the dentist?					
Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes - # packs per day:		Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes - # drinks per week:		How many hours of sleep do you get per night on average? Do you feel rested?			
Do you exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes – how often:		How many meals and/or snacks do you consume per day?		Do you eat dinner together as a family regularly? How often?			
How would you describe a “healthy lifestyle”?							
In general, would you say your health is: <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor							
Compared to one year ago, how would you rate your health in general now? <input type="checkbox"/> Much better now than one year ago <input type="checkbox"/> Somewhat better now than one year ago <input type="checkbox"/> About the same <input type="checkbox"/> Somewhat worse now than one year ago <input type="checkbox"/> Much worse than one year ago							

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Social activities:
Emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? <input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe
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SECTION B – SPIRITUAL (SPOUSE)		
How often do you attend church?	How long have you been attending FCC?	Does your entire family attend church together?
Have you been baptized by immersion?	Date of immersion	
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Do you attend Adult Bible Study Class?	What is your favorite Bible verse?	
Do you serve at FCC?	If so, where/how do you serve?	
What other groups/programs are you involved in at FCC?		

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Are you involved in religious studies/groups outside of FCC? If so, what?
I feel most connected to God when I am:

SECTION C – FINANCIAL (SPOUSE)		
Current Employer	Current Employer Address	
Job Title	Dates Employed	Income (year/month/week)
List all Current Benefits		
Previous Employer	Previous Employer Address	
Job Title	Dates Employed	Income (year/month/week)
Other sources of income (please list what type of income and amount paid)		
Income Source	Pay (year/month/week)	
Income Source	Pay (year/month/week)	
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4. I know whatever may be bothering my spouse on any given day. <div style="text-align: center; font-size: small;"> Not at All Seldom Sometimes Mostly Always </div>

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5. When we have conflicts in our marriage, usually someone wins. Not at All Seldom Sometimes Mostly Always	
6. God would smile upon our sexual intimacy, since He designed marriage, anyway, and sees all things. Not at All Seldom Sometimes Mostly Always	
7. I know by clear evidence that my spouse listens when I speak. Not at All Seldom Sometimes Mostly Always	
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16. When we have disagreements, we are able to come back to each other with dignity. Not at All Seldom Sometimes Mostly Always	
On a scale of 1 to 10, what is your relationship with your father/mother? (1=distant/rarely speak to, 10=speak to/see regularly)	Do you feel your parents taught you what you needed to know to function as an adult?

Everything provided is to the best of my knowledge.

Spouse's Signature

Date