



Starlight at Tamassee Application for Admission

About Starlight at Tamassee

Starlight at Tamassee is a faith-infused, family-centered, therapeutic community for children and their mothers who struggle with substance abuse. Starlight offers holistic, evidence-based, and trauma-informed services. The goals for Starlight Children are to heal emotionally, bond with their moms, and excel in school. The goals for Starlight Moms are to experience lasting freedom, to parent successfully, to support their children, and to live independently and productively. It takes approximately two years for families to complete the program, based on the unique needs of each family. Please see the Tamassee website and the Starlight Family Handbook for more information.

Admission Criteria

Starlight accepts pregnant women, women with children, and women who are seeking to re-establish relationships with non-custodial children. Children must be entering fourth grade or younger at admission. Starlight is a drug, alcohol, and nicotine free community. Moms must pass drug screenings to enter and remain in the program. Starlight reserves the right to deny admission in order to maintain a safe, trauma-informed environment with successful, appropriate services for each mom and child in the community.

Application Instructions

Applicants must complete the entire application. All questions must be answered legibly, accurately, and completely for Starlight Staff to process the application and to determine eligibility for admission. Questions left blank will result in a returned application. Please mark N/A if a question does not apply to you. If you need additional space, please use the back of the page. Falsifying information on the application or during the admissions process may result in denial of acceptance or dismissal from the program. The information you provide on this application is confidential and will be used solely for the purpose for which it is intended.

Please note: Signed Releases of Information (consents) may be necessary to determine eligibility.

If you have questions about the application, please call 864-944-1390.

Personal & Contact Information

Name: _____ Date of Birth: _____ Age: _____

Maiden Name/Aliases: _____ Preferred Name: _____

SSN: _____ - _____ - _____ Please check if you are a veteran? Yes No

Please check below if you can provide a copy of the following forms of personal identification.

Birth Certificate Social Security Card Driver's License/State ID

Ethnicity: _____ Primary Language: _____

Please check if you require interpreter services of any kind? Yes No

If yes, please describe your needs: _____

How did you hear about Starlight at Tamassee? _____

Please check if you have you previously applied to Starlight at Tamassee? Yes No

If yes, when? _____ What was the outcome? _____

Phone number: _____ Email: _____

If we're unable to reach you, do you give us permission to leave a detailed message with our name and contact information? Yes No

Please list the name and contact information for 2 individuals we may contact if we are unable to reach you.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Do you give us permission to leave a detailed message with our name and contact information when attempting to reach your contacts? Yes No

Housing History

Current Address: _____

Length of stay at current address: _____

Please check the box below that most accurately describes your current living situation.

Non-Housing (Street, car, etc.)

Mother and children separately living with relatives/friends

Mother and children together living with relatives/friends

Hospital

Domestic Violence Situation

Jail/Prison

Rental Housing

Emergency Shelter

Own Home

Transitional Housing for Homeless Persons

Psychiatric Facility

Substance Abuse Treatment Facility

Other: _____

Please describe your housing history for the past five (5) years: _____

Please describe your housing goals and preferences: _____

If you are currently residing in a facility, including jail or prison, please provide the following information:

Name of Facility: _____

Representative's Name and Contact Information (address and phone): _____

Date of Admission: _____ Anticipated Release Date: _____

Medical History

Please identify and describe any medical needs or conditions, including dental, vision and hearing needs, which you are currently experiencing and/or currently being treated: _____

Please provide the information below for **all** medications you are **currently prescribed**.

Medication	Prescribed For	Prescribed By	Prescribed Dose	Frequency	Date Prescribed

Please provide the information below for **all** medications prescribed for you **during the past 6 months**.

Medication	Prescribed For	Prescribed By	Prescribed Dose	Frequency	Date Prescribed

Please check below to indicate if you have ever been diagnosed with or experienced the following medical conditions:

- Hepatitis A
- Tuberculosis (TB)
- HIV/AIDS
- Hepatitis B
- Staph Infection
- Other: _____
- Hepatitis C
- COVID-19
- Other: _____

Do you have any physical disabilities? Yes No If yes, please describe: _____

Please list any allergies (food, seasonal, medication, other): _____

Do you require an EpiPen due to severe allergy? Yes No

Are you currently pregnant? Yes No If yes, how many weeks? _____ Due Date: _____

Are you currently receiving any prenatal care/services? Yes No If yes, please identify your OBGYN/pre-natal care provider and contact information: _____

Do you have any developmental disabilities? Yes No If yes, please describe: _____

Are you receiving services from the Department of Disabilities and Special Needs? Yes No

Mental Health History

Please check if you are currently, or have ever been, diagnosed with the following mental health conditions.

- | | | |
|---------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Post-Traumatic Stress Disorder | <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> Intermittent Explosive Disorder |
| <input type="checkbox"/> Obsessive-Compulsive Disorder | <input type="checkbox"/> Dissociative Identity Disorder | <input type="checkbox"/> Conduct Disorder |
| <input type="checkbox"/> Depressive Disorder | <input type="checkbox"/> Anti-social Personality Disorder | <input type="checkbox"/> Eating Disorder |

Please describe any diagnoses not listed above: _____

Please describe any other emotional concerns you may be experiencing: _____

Please check if you are currently, or have ever, received any of the following mental health services.

- | | |
|------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Mental Health Court |
| <input type="checkbox"/> Counseling/Therapy (outpatient setting) | <input type="checkbox"/> Mobile Crisis Unit |
| <input type="checkbox"/> Hospitalization (Emergency Room) | <input type="checkbox"/> Inpatient Mental Health Treatment |
| <input type="checkbox"/> Medication Management/Psychiatrist | |

How many times have you been hospitalized in the past five years? _____ Please describe the nature of any hospitalization: _____

For any services received, please list the facility name, contact information for primary clinician or worker, and dates of participation: _____

Have you ever experienced suicidal thoughts? Yes No If yes, how often do you experience these thoughts? _____

Have you ever attempted suicide? Yes No If yes, please describe (including method used): _____

Have you ever experienced homicidal thoughts? Yes No If yes, how often do you experience these thoughts? _____

Have you ever acted upon homicidal thoughts? Yes No If yes, please describe: _____

Does you have a family history of mental illness? Yes No If yes, please indicate the mental health illness and the family member diagnosed: _____

Substance Use History

Please note: Starlight at Tamassee is drug, alcohol, and nicotine free program. All non-prescribed substance use is prohibited. Random drug screening is an eligibility and residency requirement.

Please describe your substance use below.

Substance Categories	How do you use it?	Age when started?	How often do you use?	Amount used?	Your last use?	Longest period without use?	Examples include but are not limited to:
Nicotine							Vape pens, e-cigs, smokeless tobacco
Caffeine							Coffee, tea, soda, caffeine pills
Alcohol							Beer, wine, liquor, other alcohol products
Marijuana							Pot, cannabis edibles, CBD oil
Opiates							Pain pills (prescribed or non-prescribed), heroin, suboxone, methadone
Hallucinogens							LSD, ecstasy, ketamine, PCP, salvia
Other Stimulants							Cocaine, amphetamines, meth, crack, bath salts
Inhalants (Huffing)							Aerosols, gas, nitrites, cleaning liquids, glue
Sedatives/Hypnotics/Anxiolytics							Sleep medication, anxiety medication
Other – please identify							K2, Spice, Kratom, Steroids

Have you ever been enrolled in a substance use treatment program? Yes No If yes, please list the names of all program(s) in which you have participated and the dates attended: _____

Are you currently receiving MAT (*medication assisted treatment*) services? Yes No

What was the outcome of the last substance use program attended? Successful Unsuccessful

If unsuccessful completion, please explain: _____

Does anyone in your family have a history of substance use? Yes No If yes, please describe: _____

What substance(s) will be the most difficult for you to stop using? _____

Do you have a desire to stop using all non-prescribed substances? Yes No

Do you have any other type of addictions? Yes No If yes, please describe: _____

Have you ever overdosed? Yes No If yes, please describe: _____

Violence / Abuse History

Please check either Yes or No if you have experienced any of the situations below.

Are you a **survivor** of domestic violence / physical abuse? As a child? Yes No As an adult? Yes No

Have you **perpetrated** domestic violence / physical abuse? As a child? Yes No As an adult? Yes No

Are you a **survivor** of sexual assault? As a child? Yes No As an adult? Yes No

Have you **perpetrated** sexual assault? As a child? Yes No As an adult? Yes No

Do you currently have any restraining orders against anyone? Yes No If yes, please describe: _____

Do you now, or have you ever, had a restraining order taken out against you? Yes No If yes, please describe: _____

Does anyone in your family have a history of domestic violence? Yes No If yes, please describe: _____

Legal History

Please note: Background screening is part of the eligibility determination for Starlight at Tamassee.

Do you have any pending charges (for which you still have to go to court)? Yes No If yes, please describe: _____

Have you ever been convicted of a felony? Yes No If yes, please describe: _____

Please list the 5 most recent convictions/charges:

Date	County	Charge	Misdemeanor or Felony	Outcome/Sentencing

Are you currently involved with Probation and Parole services? Yes No If yes, please list for what charges, conditions, length of time yet to serve, and name and contact information (including county) of your agent: _____

Are you currently involved with the Child Welfare System (DSS)? Yes No If yes, please describe the circumstances and provide the name and contact information for your caseworker: _____

Are you a registered sex offender? Yes No If yes, please describe: _____

Are you involved with any other kind of legal matters? Yes No If yes, please describe: _____

Educational History

What is the highest grade you have completed? _____

Do you have a GED? Yes No If no, are you interested in obtaining a GED? Yes No

Do you have any learning challenges or concerns? _____

What are your educational /career goals and interests? _____

Employment History

Complete the information below for your last 3 employers. Please list the most current first.

Job Type/Title	Employer Name	Wage per Hour	Dates Worked Ex: 5/19-11/20	Reason for Leaving
			-	

			-	
			-	

Please check if you are able to perform the following tasks / jobs / actions.

- | | |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> <i>Cooking</i> : cooking, baking, dishwashing | <input type="checkbox"/> <i>Clerical</i> : computer use, phones, filing |
| <input type="checkbox"/> <i>Laundry</i> : using washer/dryer, sorting, folding | <input type="checkbox"/> <i>Cashier</i> : balancing register, changing money |
| <input type="checkbox"/> <i>Cleaning</i> : mopping, vacuuming, dusting, trash removal | <input type="checkbox"/> <i>Shopping</i> : budgeting, grocery list, shopping |
| <input type="checkbox"/> <i>Yard Work</i> : mowing, weeding, raking | <input type="checkbox"/> <i>Other</i> : _____ |

Financial Information

Please note: Starlight Moms are expected to contribute toward the cost of the program. Contributions are based on a sliding scale. No applicant will be denied access to the program due to a lack of funds. Starlight Moms are expected to apply for all benefits for which they may qualify.

Insurance

Medical Insurance: _____ Policy Number: _____
 Dental Insurance: _____ Policy Number: _____
 Other Insurance: _____ Policy Number: _____

Benefits

Please check if you are currently receiving any of the following sources of income/benefits.

- | | | |
|-------------------------------|---------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> WIC | <input type="checkbox"/> TANF | <input type="checkbox"/> SSI (Supplemental Security Income) |
| <input type="checkbox"/> SNAP | <input type="checkbox"/> SC Voucher Program | <input type="checkbox"/> SSDI (Social Security Disability Income) |

Income

Do you currently have any income? Yes No

Please list your total monthly income (from all sources) \$ _____

Do you currently have a checking or saving account? Yes No

If yes, what is the balance? Checking Account: \$ _____ Savings Account: \$ _____

Please check if you receive any of the following forms of financial support.

- | | | |
|----------------------------------------|---------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Trust Fund | <input type="checkbox"/> Disability | <input type="checkbox"/> Assistance from Family/Friends |
| <input type="checkbox"/> Child Support | <input type="checkbox"/> Unemployment | <input type="checkbox"/> Other: _____ |

Please identify anyone who will be providing you with financial support if you are admitted to Starlight:

Expenses

Please check if you have any of the following monthly expenses and list the amount for those that apply.

- Child Support – Amount: \$ _____ Rent – Amount: \$ _____
 Car Payment – Amount: \$ _____ Phone – Amount: \$ _____
 Restitution – Amount: \$ _____ Probation/Parole Fees – Amount: \$ _____
 Loan: _____ – Amount: \$ _____ Other _____ – Amount: \$ _____

What are your total monthly expenses (from all sources) \$ _____

Spiritual History

Please note: Starlight at Tamasee is a loving, grace-filled, faith-infused Christian community. Moms are not required to be Christians to be admitted into the program, nor are moms and children required to express a commitment to Christian faith while participating in the program. Starlight Families are expected to participate in various spiritual activities (including, but not limited to, times of prayer and meditation, Christ-centered curriculum and Bible studies, and chapel and worship service attendance).

Please describe your experiences with faith and spirituality in the home(s) you grew up in: _____

Please describe your experiences with spiritual leaders or authority figures: _____

Please list all religious and/or spiritual organizations you are now involved in or have been in the past:

Please describe spiritual practices you have engaged in, past and present, and which are important to you:

Is spiritual growth important to you? Yes No

Relationship Status and Children

Please note: Starlight Moms are not allowed to engage in romantic relationships or sexual activity on or off campus while in Starlight at Tamasee. Starlight admits children entering fourth grade and younger.

Partner Status

What is your marital status? Single Married Separated Divorced Widowed

Are you currently involved in a romantic relationship? Yes No

How do you feel about the policy that Starlight Moms are to have no romantic relationships or sexual activity for the duration of the program? _____

Children's Information

How many children do you have? _____ How many children will come with you? _____

Please answer the following questions about each of your children.

Child's Name: _____ Date of Birth: _____ Sex: F M

Name of Father: _____ Name of Person with Custody: _____

Do you communicate with your child's father? Yes No Is your child's father involved? Yes No

Describe any concerns about your child's father: _____

Grade: _____ IEP/504 Plan: Yes No School Attended: _____

List all developmental or physical disabilities and medical conditions: _____

List all mental health diagnoses: _____

List all mental health providers: _____

Has this child ever verbalized thoughts of hurting self or others? Yes No If yes, please describe: _____

Child's Name: _____ Date of Birth: _____ Sex: F M

Name of Father: _____ Name of Person with Custody: _____

Do you communicate with your child's father? Yes No Is your child's father involved? Yes No

Describe any concerns about your child's father: _____

Grade: _____ IEP/504 Plan: Yes No School Attended: _____

List all developmental or physical disabilities and medical conditions: _____

List all mental health diagnoses: _____

List all mental health providers: _____

Has this child ever verbalized thoughts of hurting self or others? Yes No If yes, please describe: _____

Child's Name: _____ Date of Birth: _____ Sex: F M

Name of Father: _____ Name of Person with Custody: _____

Do you communicate with your child's father? Yes No Is your child's father involved? Yes No

Describe any concerns about your child's father: _____

Grade: _____ IEP/504 Plan: Yes No School Attended: _____

List all developmental or physical disabilities and medical conditions: _____

List all mental health diagnoses: _____

List all mental health providers: _____

Has this child ever verbalized thoughts of hurting self or others? Yes No If yes, please describe:

Child's Name: _____ Date of Birth: _____ Sex: F M

Name of Father: _____ Name of Person with Custody: _____

Do you communicate with your child's father? Yes No Is your child's father involved? Yes No

Describe any concerns about your child's father: _____

Grade: _____ IEP/504 Plan: Yes No School Attended: _____

List all developmental or physical disabilities and medical conditions: _____

List all mental health diagnoses: _____

List all mental health providers: _____

Has this child ever verbalized thoughts of hurting self or others? Yes No If yes, please describe:

Personal Goals

My personal goal and dream for myself: _____

My personal goal and dream for my child(ren): _____

Describe how you feel about a two year commitment to Starlight at Tamassee: _____

What concerns do you have about living in a community setting or at Starlight at Tamassee overall: _____

Describe why you're interested in coming to Starlight and how you feel you would benefit: _____

Acknowledgements and Waivers

Please initial each statement you acknowledge and to which you assent.

_____ I acknowledge that I completed this application in its entirety truthfully.

_____ I acknowledge and understand that Starlight at Tamassee is a sober-living program.

_____ I acknowledge and understand that Starlight at Tamassee is not a detox facility or licensed substance treatment facility, and I waive my right to any legal action against Starlight at Tamassee and any program volunteers based on any counsel I receive.

_____ I acknowledge and understand that Starlight at Tamassee is not a medical program.

_____ I acknowledge and understand that Starlight at Tamassee does not provide or pay for medications.

_____ I acknowledge and understand that Starlight Moms will perform job duties while enrolled in the program, and I waive my right to legal action against Starlight at Tamassee should I be hurt while engaging in work activities.

_____ I acknowledge and understand that Starlight Moms will be provided limited transportation while enrolled in the program, and I waive my right to legal action against Starlight at Tamassee should I be hurt while being transported in any of the company vehicles.

If anyone assisted you in completing your application please provide their name and their relationship to you: _____

Applicant Signature: _____ Date: _____

Instructions for Returning the Application

Return completed applications in one of the following ways.

- Scan and Email to starlight@tdarschool.org
- Fax to **(864) 944-0097**
- Mail to Tamassee DAR School / Attn: Starlight Admissions / PO Box 8 / Tamassee, SC 29686
- Drop Off in Person at Tamassee Administration Bldg. / 1925 Bumgardner Dr. / Tamassee, SC 29686