

**Application Questionnaire – SVABW EAP Program**

Name (First, Middle I., Last): \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mobile Telephone: \_\_\_\_\_

Marital Status (check one): Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_

Number of Children: \_\_\_ Ages of Children: \_\_\_\_\_

Are you able to arrange childcare? 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? 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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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