

**ST. JOSEPH CENTER CULINARY TRAINING PROGRAM  
APPLICATION**

This space for office use only – <b>do not fill out</b>					
Interview Date: _____		Interviewer _____			
Accepted:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Graduation Date _____		
Referred by: _____		Program: CTP 2 <sup>ND</sup> yes _____ no _____			
THE FOLLOWING INFORMATION IS CONFIDENTIAL (PLEASE PRINT CLEARLY)					
<i>Note: Withholding or falsifying information can result in termination from the Culinary Training Program at any time during the 10-week program.</i>					
Name:		Date: _____ (MM/DD/YYYY)			
Address:		DOB: _____ (MM/DD/YYYY)			
City:		Zip: _____	Age: _____		
Phone Number: _____		# of Children: _____			
Email Address: _____		Ages of Children: _____			
California ID #: _____		Exp: _____	Marital Staus: _____		
Are you part of any other program at St. Joseph Center? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If yes, program name: _____		Case Manager: _____			
Have you ever applied to the Culinary Training Program? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If yes, were you accepted? Yes <input type="checkbox"/> No <input type="checkbox"/>			If yes, when? _____		
Have you taken classes with the Culinary Training Program? Yes <input type="checkbox"/> No <input type="checkbox"/>			When? _____		
<b>EDUCATION</b>	Name	When Attended	Graduate?		Area of Study
High School			Yes <input type="checkbox"/>	No <input type="checkbox"/>	GED <input type="checkbox"/>
College			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Vocational			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Special Skills:					
Hobbies:					
<b>WORK HISTORY</b>					
Start with last job worked	Type of Work	Date Work Started	Date Work Ended	Reason for Leaving	
If you are accepted into the Program would you prefer to take the Serve Safe Test in English <input type="checkbox"/> or Spanish <input type="checkbox"/> ?					

**LEGAL HISTORY INTAKE FORM**

ST. JOSEPH CENTER CULINARY TRAINING PROGRAM WORKS IN CONJUNCTION WITH AN EDUCATIONAL FACILITY AND GOVERNMENT ORGANIZATION THAT REQUIRE BACKGROUND CHECKS BEFORE ACCEPTANCE INTO THE FOUR WEEK INTERNSHIP.

- ALL PRIOR FELONY CONVICTIONS AND MISDEMEANORS ARE NOT EXEMPT FROM YOUR BACKGROUND CHECK. MEANING ANY EXPUNGED, SEALED OR CLOSED CONVICTIONS OR MISDEMEANORS WILL BE LISTED ON THE BACKGROUND CHECK DONE BY UCLA DINING SERVICES.
- IT DOES NOT MATTER WHEN THE CONVICTION OCCURRED: ABSOLUTELY EVERY MISDEMEANOR AND FELONY CONVICTION WILL BE IDENTIFIED ON THE BACKGROUND CHECK.
- NEW DIRECTIONS INC. REQUIRES A BACKGROUND CHECK. YOU MUST LIST ALL MISDEMEANORS AND PRIOR FELONIES FROM THE PAST 10 YEARS REGARDLESS IF THEY HAVE BEEN SEALED, EXPUNGED, OR CLOSED. WITHHOLDING INFORMATION WILL KEEP YOU FROM BEING ACCEPTED.

TO ENSURE PROPER PLACEMENT WITH OUR PROGRAM BASED ON MISDEMEANORS OR FELONIES IT IS OF THE UTMOST IMPORTANCE THAT YOU DO NOT WITHOLD INFORMATION.

List ALL misdemeanors:	Explain outcome:	Month/Year

List ALL felony convictions (AND INCLUDE ALL THAT HAVE BEEN SEALED, EXPUNGED AND CLOSED)

Felony:	Explain outcome:	Month/Year

Are you currently part of Proposition 36?	If yes, when will it end?
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Do you have any court cases needing to go before a judge?	
Are you on Parole	Parole Officer's Name:
	Telephone Number:

Are you on Probation	Probation Officer's Name:
	Telephone Number:

Do you have any outstanding warrants?	Do you have any outstanding Traffic Tickets?
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LIST ANY ADDITIONAL INFORMATION PERTAINING TO YOUR LEGAL HISTORY THAT MAY BE IDENTIFIED IN THE BACKGROUND CHECK. \_\_\_\_\_

Why are you unemployed now? \_\_\_\_\_

How long have you been unemployed? Months: \_\_\_\_\_ Years: \_\_\_\_\_

Have you ever been fired? Yes  No  Explain: \_\_\_\_\_

Have you attended or been referred to anger management classes in the past? Yes  No

Explain: \_\_\_\_\_

**INCOME - What is the source of your income?**

Unemployment Benefits Yes  No  Due to enddate(MMDD\YYYY):  
Program – check: GAIN  GR  GROW  SSI  Dept of Aging (Title V)  AFDC   
Other – please specify: \_\_\_\_\_ Case manager: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ FAX: \_\_\_\_\_  
When did income from this program begin? \_\_\_\_\_ Will you continue to receive benefits during the 10 weeks of the program? Yes  No

If not receiving income from one of the above programs, what will be source of income during class?

Employed? Yes  No  Supported by someone else? Yes  No

**Your annual income:** \_\_\_\_\_

**Your Spouse's Income:** \_\_\_\_\_

If you live (and are supported by your parents) what is their combined income? \_\_\_\_\_

**HOW DO YOU FEEL ABOUT MINIMUM WAGE?**

\_\_\_\_\_

**MEDICAL HISTORY**

Do you plan to have any surgery within the next year? Yes  No  When?: \_\_\_\_\_

Do you plan to have any dental work within the next year? Yes  No  When?: \_\_\_\_\_

Previous Hospitalizations Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Physical Therapy Condition: \_\_\_\_\_ Date: \_\_\_\_\_

Condition: \_\_\_\_\_ Date: \_\_\_\_\_

Currently working with physical therapist? Yes  No

Back Injuries Yes  No  Explain: \_\_\_\_\_

Workers Comp Yes  No  Explain: \_\_\_\_\_

Physical Limitations Yes  No  Explain: \_\_\_\_\_

Work Restrictions Yes  No  Explain: \_\_\_\_\_

Current Meds Yes  No  Explain: \_\_\_\_\_

**HISTORY OF PAST ILLNESS/INJURY – CHECK EACH ILLNESS/INJURY YOU HAVE HAD**

<input type="checkbox"/> Mumps	<input type="checkbox"/> Lacerations (extensive)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Feet (fallen arches)
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other Serious Injury	<input type="checkbox"/> Nervous Breakdown
<input type="checkbox"/> Shingles	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Concussions	<input type="checkbox"/> Cancer	<input type="checkbox"/> Asthma
<input type="checkbox"/> Sprains/Dislocations	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Auto Accident	<input type="checkbox"/> Hives/Hay fever
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Knocked Out	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Hepatitis B

Comments for checked illnesses/injuries: \_\_\_\_\_

Do you feel that you are physically able to work in a kitchen?

List any physical activities that you do: \_\_\_\_\_

**MENTAL HEALTH HISTORY**

Have mental health issues (depression, schizophrenia, etc.) prevented you from working in the past? Yes  No

Have you ever been diagnosed with a mental illness? Yes  No

If yes, are you currently under case management? Yes  No

How long have you been under case management?

Where do you receive case management?

Mental Health case manager:

Psychological

Medication:

Prescribed for:

Medication/s:

Medication:

Prescribed for:

Medication:

Prescribed for:

**Note: You must agree to stay under the care of your mental health case manager and agree to take all prescribed medication/s to be able to continue in the Culinary Training Program.**

**ALCOHOL AND DRUG USE**

Do you drink alcohol? Yes  No  If yes, how much/how often?

If no, are you in recovery? Yes  No  Time Sober: Years: Months: Days:

Have you ever used drugs? Yes  No  If yes, how much/how often?

If yes, are you in recovery? Yes  No  Time Clean: Years: Months: Days:

List drugs you have used

Have you ever attended 12-step meetings? Yes  No  Currently attending meetings? Yes  No

Has drug or alcohol use kept you from working or caused you to be fired from a job? Yes  No

Have you ever been unemployed for more than six months at a time? Yes  No

If yes, explain:

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**HOUSING**Are you currently homeless (living in transitional housing?) Yes  No 

If no, how long at your current residence?	Do you pay or contribute to the rent at the residence?
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you live with family? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you live with friends? Yes <input type="checkbox"/> No <input type="checkbox"/>

*If yes, please explain what circumstances caused you to move into transitional housing:*

How many years have you been homeless (i.e., staying with a friend, living on the street, etc.) prior to moving into transitional housing?

Name of transitional institution where you currently reside:

How long have you been there?

How long can you stay there?

Do you plan to stay there during the 10-week program? Yes  No **Previous transitional housing**

Location

Dates of residence

From: To:

From: To:

From: To:

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**TRANSPORTATION**

How do you plan to get to school? (check one)

Do you have a bus pass or income to provide it?

Bus Car Yes No 

Bus Route?

Have you ever used services from the Department of Rehabilitation?

Yes No 

Currently receiving services from the Department of Rehabilitation?

Yes No **TRAINING PROGRAMS – List any free or low-cost training programs you have participated in**

Name of program	Dates	Length of program	Completed?

Can you provide proof of completion? Yes  No **MILITARY SERVICE**

Branch:

Years of Service:

Discharge:

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**List ALL appointments such as court dates, medical, childcare, public social service, GROW, GAIN, parole, probation you have scheduled during the 10 weeks of the program between 8am to 5pm**

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**SUPPORT SYSTEMS**

Family Member you are in contact with:

Telephone:

Friends in the area:

Telephone:

Telephone:

Telephone:

Church    Yes     No

Civic/Social Group:

**Describe in detail an example (within the past 6 months) when you participated as a team member. This does not need to be a work experience. A volunteer experience will also be accepted.**

**Describe in detail why you should be accepted into the Culinary Training Program**

I have answered the above questions and I understand that withholding or falsifying information can result in termination at any time from the Culinary Training Program during the 10-weeks.

Name (print)

Signature

Date