



Home of the Brave, Inc.  
1038 Highway 305 North  
Senatobia, Mississippi 38668  
662-418-8888  
home4brave@gmail.com

Dear Applicant,

My name is Kelly Crabtree. I am the director of Home of the Brave, Inc. I can assist you in becoming an eligible candidate for one of our retreats, camps, or monthly programs and ultimately becoming a part of the Home of the Brave, Inc. family.

For a successful application please follow the process below:

1. Submit application AND a copy of the following:
  - a. Complete copy of DD-214
  - b. Copy of Military ID

If you would like to come to the ranch participating in the 1 month or 2-month ranch programs, we will also need a copy of the following...

- c. Copy of Social Security Card (Monthly Ranch Programs only)
- d. Copy of Criminal Record (Monthly Ranch Programs only)
- e. (2) References from Commanding Officers you served under (Monthly Ranch Programs only)
- f. Remain free of drugs and the legal system
- g. Attend mandatory interview (Monthly Ranch Programs only)

I look forward to welcoming you to Home of the Brave, Inc. If you have any questions please feel free to email, text or call me so I can assist you.

Love In Christ,

Kelly Crabtree  
Home of the Brave, Inc. Director

Which Program(s) are you Interested in attending?

- \_\_\_\_\_ Mens Retreat
- \_\_\_\_\_ Ladies Retreat
- \_\_\_\_\_ Horsemanship / Bushcraft Camp I
- \_\_\_\_\_ Horsemanship / Bushcraft Camp II
- \_\_\_\_\_ Mountain Pack Trip
- \_\_\_\_\_ 1 Month Ranch Program
- \_\_\_\_\_ 2 Month Ranch Program

## Home of the Brave, Inc.

### Veterans Application to Participate

Applicants Name \_\_\_\_\_ Todays Date \_\_\_\_\_ Military SN \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Other (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: Male\_\_ Female\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Ethnicity: American Indian\_\_ Asian\_\_ Black\_\_ Hispanic\_\_ White\_\_ Other \_\_\_\_\_

Email: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Mailing address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Married Yes\_\_ No\_\_ Number of Children \_\_\_\_\_ Who will keep children while you  
are in the program? \_\_\_\_\_

Spouses Name: \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Mother / Guardian \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

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

Mailing address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father/ Guardian \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

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

Mailing address: \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Emergency Contact #1 \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

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

Mailing address: \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

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

Mailing address: \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How many siblings do you have? \_\_\_\_\_ List their names and contact information here.

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Please make a copy of this page if you need more spaces.

Are you currently working in civilian employment? Yes \_\_\_\_\_ No \_\_\_\_\_

List Place of Employment \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Employment mailing address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Supervisors Name: \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Basic Job Duties \_\_\_\_\_ May I contact your employer? Yes \_\_\_ No \_\_\_

**Doctor Information:**

Medical Doctors Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Mailing address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is your doctor available for a consultation regarding this application? Yes \_\_\_ No \_\_\_

Are you currently being treated by a psychiatrist for a service related disability? Yes \_\_\_ No \_\_\_

Psychiatrist Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Mailing address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is your psychiatrist available for a consultation regarding this application? Yes \_\_\_ No \_\_\_

**Disability Information:**

What is your primary diagnosis: \_\_\_\_\_

What other medical conditions do you have? \_\_\_\_\_

How are your daily living skills affected? \_\_\_\_\_

What are your limitations? \_\_\_\_\_

Do you have any physical restrictions or precautions you must take because of your diagnosis? \_\_\_\_\_

What type of medical treatment are you currently receiving? \_\_\_\_\_

Have you had any of the following injuries or conditions:

- |                             |                     |                  |
|-----------------------------|---------------------|------------------|
| ____ Head Injury Concussion | ____ Shoulder L / R | ____ Knees L / R |
| ____ Elbow L / R            | ____ Hip L / R      | ____ Foot L / R  |

\_\_\_ Chronic Shin Splints  
\_\_\_ Arm/Wrist/Hand L / R  
\_\_\_ Lower Leg L / R  
\_\_\_ Chest  
\_\_\_ Seizures  
\_\_\_ COPD  
\_\_\_ Hernia  
\_\_\_ Organ Loss  
\_\_\_ Diabetes  
\_\_\_ Mononucleosis/Enlarged Spleen

\_\_\_ Pinched Nerve  
\_\_\_ Back  
\_\_\_ Ankle L / R  
\_\_\_ Are you Pregnant? \_\_\_ mo/due Date  
\_\_\_ Kidney Disease  
\_\_\_ Heart Disease  
\_\_\_ High Blood Pressure  
\_\_\_ Asthma  
\_\_\_ Tuberculosis  
\_\_\_ PTSD

\_\_\_ Neck Injury/Stinger  
\_\_\_ Thigh L / R  
\_\_\_ Severe Muscle Strain  
\_\_\_ Heart Murmur  
\_\_\_ Irregular Pulse  
\_\_\_ Liver Disease  
\_\_\_ Dizzy/Fainting  
\_\_\_ Knocked Out  
\_\_\_ Overnight in Hospital  
\_\_\_ Other \_\_\_\_\_

List any previous surgeries:

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List any Allergies (food, drugs, etc.)

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List name and dosage of all medications you are currently taking. Include Prescription and over the counter and list the reason for taking each medicine.

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List any conditions not mentioned above that Home of the Brave, Inc. needs to be aware of or any special needs you may have to be successful in the program. \_\_\_\_\_

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What type(s) of adaptive equipment do you use? (i.e. manual wheelchair, power chair, walker, cane, hearing aid, etc.)

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When did you join the armed forces? \_\_\_\_\_ Branch \_\_\_\_\_

Are you discharged from the armed forces? Yes \_\_\_\_\_ No \_\_\_\_\_

What type of discharge? \_\_\_\_\_

Highest Rank Achieved? \_\_\_\_\_

In which theater(s) of conflict(s) and campaigns did you serve? \_\_\_\_\_

Please describe your service related injuries and the circumstances under which they occurred \_\_\_\_\_

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# Code of Conduct while at Home of the Brave, Inc.

Initial each statement after reading

\_\_\_ I am freely and voluntarily signing up for one of Home of the Brave, Inc.'s veteran programs.

\_\_\_ I understand that there are risks involved with living, working and participating on a farm/ranch.

\_\_\_ I will hold harmless Home of the Brave, Inc., C3 Farms, and /or Home of the Brave, Inc.'s Board of Directors and /or Volunteers or anyone working for or volunteering, owners and operators; for any injury incurred while visiting farm or participating in activities on the grounds.

\_\_\_ I am not a user of illegal substances.

\_\_\_ While I am enrolled in the Home of the Brave, Inc. monthly program, I agree to random drug testing.

\_\_\_ After I attend a retreat, camp, or monthly program, I know I must reapply and be accepted in order to continue to live and participate in other programs at the Home of the Brave, Inc. facility.

\_\_\_ I understand that alcohol and non-prescribed drugs are not allowed on the premises.

\_\_\_ I understand that fighting, bullying or any other forms of aggressive behavior will lead to termination of my eligibility to complete the retreat/camps/monthly programs.

\_\_\_ I understand that behaving in a manner which is potentially dangerous to self and others will lead to termination of my eligibility to complete the retreat/camps/monthly programs.

\_\_\_ I understand that behaving in a manner which damages or vandalizes the property of others or Home of the Brave, Inc. or C3 Farms will lead to termination of my eligibility to complete the retreat/camps/monthly programs.

\_\_\_ I understand that this is a Christian Transitional facility for Veterans of the United States Armed Forces.

\_\_\_ I understand that I am free to come and go from Home of the Brave, Inc. as needed while in the program using my own transportation. Weekend retreats require you to stay the weekend.

\_\_\_ I understand that I may have friends and family on the farm during designated visiting times only, unless prior arrangements have been made.

\_\_\_ I understand that foul language and rude behavior is not becoming of a young man or lady and I will refrain from it as long as I am at the ranch.

\_\_\_ I understand that if I break the Code of Conduct Contract it will lead to termination of my eligibility to complete the retreat/ program.

I have read the above Code of Conduct and agree to follow but my conduct is not limited to the above rules. I will conduct myself in a way that is mannerly and appropriate.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name here \_\_\_\_\_