



# ***Recovery Community Organization***

**DATE OF APPLICATION:** \_\_\_\_\_

**CONFIDENTIAL**

The purpose for this application is to assess eligibility for admission to The Esther House, the women's recovery house of Mission Missouri. Information disclosed is confidential and will be seen only by the Recovery Team for screening purposes. Completion of this documentation is voluntary. In order to be considered, this application must be completed in full. Failure to complete this application will result in a decline in possible services. Discovery of falsification of information once the resident is in the program will result in immediate dismissal.

**PLEASE PRINT and FILL OUT COMPLETELY**

**Name:** \_\_\_\_\_ **Age** \_\_\_\_\_

**Previous or Permanent Address:** (non DOC) \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**County:** \_\_\_\_\_ **Phone #** \_\_\_\_\_ **E-mail** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**Who referred you to us?** \_\_\_\_\_

**Parole/Probation Officer:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**DOC#** \_\_\_\_\_ **OUT DATE** \_\_\_\_\_

**Current Employment Information**

**Place of Employment (if employed):** \_\_\_\_\_

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

Supervisor: \_\_\_\_\_ Employment Phone # \_\_\_\_\_

Describe your previous work history or trade: \_\_\_\_\_

**IN CASE OF EMERGENCY, NOTIFY** (prefer nearest relative)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Health Care Practitioners: \_\_\_\_\_

Phone: \_\_\_\_\_

Health Insurance: \_\_\_\_\_

Name of Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

**MARITAL STATUS** (*please circle one*)

Single   Divorced   Married   Separated   Widowed

**Name of Significant other:** \_\_\_\_\_ Phone: \_\_\_\_\_

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

**CHILDREN:**

Do you have children?   Yes   No   If yes, how many children do you have? \_\_\_\_\_

Are you currently pregnant?   Yes   No

Are any of your children living with someone else due to a child protection court order?

[IF YES] How many of your children are living with someone else due to a child protection court

order? \_\_\_\_\_ Where are they living and with whom? \_\_\_\_\_

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For how many of your children have you lost parental rights? \_\_\_\_\_

**SPIRITUAL BACKGROUND (Circle Yes or No)**

**Religious affiliation:** \_\_\_\_\_

**Do you attend church?** Yes No

**EDUCATION (Circle Yes or No)**

**Highest Grade Completed:** \_\_\_\_\_ **Diploma:** Yes No

**G.E.D.:** Yes No **If yes, date received & where:** \_\_\_\_\_

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**Any College, Jr. College, or Technical School?** Yes No

**If Yes, explain:** \_\_\_\_\_

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**LEGAL/COURT HISTORY (Circle Yes or No)**

**(LOCAL PROBATION AND PAROLE HAS TO APPROVE OFFENDERS; PREFER CLIENTS FROM THIS AREA)**

**Are you involved in any active cases or current charges (civil, traffic, criminal)?** Yes No

**If yes, list charges and location:** \_\_\_\_\_

**If yes, indicate the court hearing or trial dates:** \_\_\_\_\_

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**If presently incarcerated, please state what for and your**

**outdate:** \_\_\_\_\_

**Are you presently on probation or parole?** Yes No

*If yes, (include DOC #)explain:* \_\_\_\_\_  
\_\_\_\_\_

**Do you have any pending cases or active warrants?** Yes No

*If yes, explain what and where they are:*  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have a back up home plan?** Yes No

*If yes, what is it?* \_\_\_\_\_

**DO YOU HAVE ANY PAST, CURRENT, OR PENDING SEX OFFENSE CONVICTIONS?** Yes No

**Incarceration History Dates:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TREATMENT HISTORY: (Circle Yes or No)**

**Have you participated in a therapeutic community while incarcerated?** Yes No **If Yes.**

Program: \_\_\_\_\_ Date Started \_\_\_\_\_ End Date \_\_\_\_\_  
Program: \_\_\_\_\_ Date Started \_\_\_\_\_ End Date \_\_\_\_\_  
Program: \_\_\_\_\_ Date Started \_\_\_\_\_ End Date \_\_\_\_\_

**Have you attended any substance abuse treatment programs?** Yes No

If yes, name of program and dates attended: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever attended A.A., N.A., Al-Anon, Footprints, Celebrate Recovery, or**

**Alcoholics Victorious or any other self-help group?** Yes No **If Yes.....**

When? \_\_\_\_\_ Name of Program: \_\_\_\_\_

**4. Have you ever attended a SATOP program?** Yes No **If Yes.....**

When? \_\_\_\_\_ Reason: (DWI, MIP, etc.) \_\_\_\_\_

### **DRUG USE HISTORY**

**At what age did you first use drugs and/or alcohol?** \_\_\_\_\_

**When was your last drink or other drug use?** \_\_\_\_\_

**Have you ever experienced any of the following when using alcohol or other drugs? (Check all that apply)**

Loss of memory\_\_\_\_ DTs\_\_\_\_ Seizures\_\_\_\_ Hallucinations\_\_\_\_ Flashbacks\_\_\_\_

Blackouts\_\_\_\_ Extreme Fatigue\_\_\_\_ “Shakes”\_\_\_\_ Insomnia\_\_\_\_

### **DRUG ABUSE HISTORY**

<i>Name of Drug</i>	<i>Last Used</i>	<i>How Often</i>	<i>How Much</i>	<i>Method</i>

**How did you get involved with drugs?** \_\_\_\_\_

\_\_\_\_\_

### **DRUG OF CHOICE**

**Primary:** \_\_\_\_\_ **Secondary:** \_\_\_\_\_

**Your longest dry period was from** \_\_\_\_\_ **to** \_\_\_\_\_

**Are you attending AA/NA or any other self-help organization?** Yes No

**If yes, what were you attending and how often?** \_\_\_\_\_

**Did you have a sponsor?** Yes No

**Have you ever practiced the principles of the steps?** Yes No

**MENTAL AND PHYSICAL HEALTH** *List all medication (prescriptions and non-prescription) currently taking: (Circle Yes or No)*

<u>Name of Medication</u>	<u>Dosage/How Often</u>	<u>Why Taken</u>	<u>Name and Phone of Prescribing MD</u>

**Are you allergic to any medications?** Yes No

*If so, please list:* \_\_\_\_\_

**Have you ever been treated for psychiatric problems?** Yes No

**If yes, what was the diagnosis?** \_\_\_\_\_

**Did you or are you on any meds for that problem?** Yes No

**If so, what meds and what dosage?** \_\_\_\_\_

**Have you ever THOUGHT of attempting suicide?** Yes No

**Have you ever PLANNED your own suicide?** Yes No

**Have you ever ATTEMPTED suicide?** Yes No

**Do you have any physical problems for which you are receiving treatment?** Yes No

*If yes, please identify the problem and the prescribed treatment.* \_\_\_\_\_

**Are you HIV positive?** Yes No

**Do you have Hep C?** Yes No

**Hep B?** Yes No

**Do you have TB?**      Yes   No      *If yes, is it active or inactive?* \_\_\_\_\_

**Whom are you seeing for primary health care?** *(Name of doctor(s) and phone numbers):*

Do you have Medicaid? \_\_\_\_\_ Are you eligible for Food Stamps? \_\_\_\_\_

**Is there any medical/psychological conditions or medications you are taking that would hinder you from The Esther House recovery process?**    Yes   No

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

**Do you have a car:** *(make, model, year, license plate)* \_\_\_\_\_

**Car insurance:** \_\_\_\_\_

**Name of Carrier:** \_\_\_\_\_

**Policy # and Expiration Date:** \_\_\_\_\_

**Valid Driver's License:** \_\_\_\_\_  
ID# \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Valid State Registration:** \_\_\_\_\_  
State \_\_\_\_\_ Expiration Date \_\_\_\_\_

**What do you hope to accomplish by living at The Esther House?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please submit the full application, including the SIGNED RELEASE OF INFORMATION FORM to:**

**(If submitting from D.O.C., updated summarized progress report from case worker must be submitted along with application.)**

**Mission Missouri  
509 Ruth Street  
Sikeston, Mo. 63801  
Or by fax  
573-481-0518  
missionmissouriapplication@gmail.com**

**If you have any questions  
Phone 573-481-0505  
Hours 9:00 A.M.-5:00 P.M. Mon-Fri**