MISSION Missouri
A Center of Hope & Restoration

Recovery Community Organization

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?_____

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***: _____

_____

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

If Yes, explain: _____

_____

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: _____

_____

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? 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

Name of Drug	*Last Used*	*How Often*	*How Much*	*Method*

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)***

Name of Medication	***Dosage/How Often***	***Why Taken***	***Name and Phone of Prescribing MD***

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):***

_____

_____

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