601 Apple Street

573-686-3333 phone
573-686-3334 fax

Application

PLEASE PRINT **TODAY'S DATE**_____

PERSONAL INFORMATION

Full Name:

_____

Address:

_____

City: _____**State:** _____**Zip:** _____

Home Phone: _____**Cell :** _____**Work :** _____

Date of Birth: _____ **Age:** _____ **SS #:** _____

Please place an X in the appropriate box that describes the above address

- ❑ **Permanent Address**
- ❑ **Temporary Address**
- ❑ **Treatment Facility**
- ❑ **Jail/Prison**
- ❑ **Other**

If other, please explain:_____

_____

Release Date: _____

IPO Name: _____ **DOC #:** _____

EMERGENCY CONTACT INFORMATION

Name:_____Relationship:_____

Address: _____

City: _____State: _____Zip: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____

EMPLOYMENT INFORMATION

Are you presently employed? _____

If no, how long have you been unemployed: _____

If yes, Name of Employer:_____

Position: _____

Full or Part Time_____

Length of time at current job: _____Rate of Pay: _____

How often are you paid: _____

FAMILY INFORMATION

Are you married? _____Divorced? _____Widowed? _____Single? _____

Do you have any children? _____ If yes, how many? _____

What are there ages and genders:

_____

Do they live with you? _____Do you have sole custody? ____Joint custody? _____

If not, who do they live with?_____

EDUCATION INFORMATION

What is the highest grade you have completed? _____

If you did not graduate, do you want to receive your G.E.D.?_____

SPIRITUAL INFORMATION

Do you have any religious or spiritual affiliations? _____

If yes, what: _____

Do you attend church now? _____Have you in the past? _____

How often? _____

Please describe your relationship with God or your Higher Power:

_____

_____

_____

_____

_____

_____

_____

INSURANCE & SERVICES INFORMATION

Do you have insurance: _____If yes, please place an X in the box(s) that apply to you:

- ❑ **Private Insurance**
  - o **Company Name & Policy#_____**
- ❑ **Medicare**
  - o **Policy#_____**
- ❑ **Medicaid**
  - **Policy#_____**

Do you receive any of the following services? _____
If yes, please place an X in the box(s) that apply to all services that you receive

❑	**Social Security Disability**	**Monthly amount:_____**
❑	**SSI**	**Monthly amount: _____**
❑	**Food Stamps**	**Monthly amount: _____**
❑	**TANIF**	**Monthly amount: _____**
❑	**Other**	**Please explain: _____**

If no, have you applied for any of the above services within the last 90 days?_____

If no, have you been denied for any of the above services within the last 90 days?___

If yes, what were the reasons you were denied?_____

_____

_____

_____

_____

_____

MEDICAL INFORMATION

Physicians Name:_____

Address:_____

City: _____State:_____Zip: _____

Office Phone: _____Specialty:_____

If you have more than one physician, please list all the same information as above for each physician on another sheet of paper and attach it to the last page of this application

Have you ever required Psychiatric counseling? _____If yes, please explain in detail.

_____

_____

_____

_____

PLEASE LIST ALL MEDICATION BOTH *PRESCRIBED* AND *OVER-THE-COUNTER* THAT YOU TAKE

PRESCRIBED MEDICATIONS

Medication Name	Physicians Name	Dosage Amount	When Taken	Medication Reason

OVER-THE-COUNTER MEDICATIONS

Medication Name	Dosage Amount	Why do you feel you need this medication?

CURRENT USE CHART

DRUG	LAST USED	FREQUENCY OF USE	USUSAL DOSAGE	ROUTE OF DELIVERY	COMMENTS
None					
Alcohol					
Marijuana/ Hashish					
Cocaine					
Amphetamine					
Methampheta mines					
Heroine					
Non-RX Methadone					
Other Opiates/ Synthetics					
Barbiturates					
Tranquilizers					
Sedatives/ Hypnotics					

Hypnotics					
Hallucinogens (specify)					
PCP					
Inhalants					
Psychotropic's					
Other					

Primary "Drug of Choice":_____

Secondary:_____

Have there ever been incidents of overdose, withdrawal or adverse reaction to drugs or alcohol?

Yes/No If Yes, Please Describe:

_____

_____

_____

_____

List any substance abuse education programs you have attended:

_____

_____

_____

LEGAL HISTORY (ASSOCIATED WITH CHEMICAL USE/ALCOHOL)

CHARGE	DATE	AGE	LOCATION	USE INVOLVEMENT

Do you have any pending legal cases? Yes/No If yes, place an X in the box of all that apply:

- ❑ **Traffic Violations**
- ❑ **Civil Involvements**
- ❑ **Criminal Involvements**

If you answered yes to any of the above, please complete the following:

Date: _____ Charge: _____

Status of Violation/Involvement: _____

_____

_____

_____

_____

_____

<u>PROBATION AND PAROLE INFORMATION</u>

Name: _____ Location: _____

Phone Number: _____

How long have you been or were you on probation/parol _____

What reason were you or are you on probation/parole _____

_____

_____

_____

TREATMENT HISTORY

How many substance abuse treatment programs have you been to in the past? Where? How Long?

_____

_____

_____

_____

_____

What would you like to receive from Recycling Grace Women's Center?

_____

_____

_____

_____

_____

_____

What goals would you like Recycling Grace Women's Center to help you achieve?

_____

_____

_____

_____

_____

_____

What areas do you feel you need assistance in? Please place an X in all boxes that apply:

- ❑ **Family**
- ❑ **Relationships**
- ❑ **Spiritual**
- ❑ **Educational**
- ❑ **Sexual**
- ❑ **Financial**
- ❑ **Legal**
- ❑ **Life Skills**
- ❑ **Mental Health**
- ❑ **General Health**
- ❑ **Other**

Please describe in detail each of the following boxes that you marked with an X:

_____

_____

_____

_____

_____

_____

_____

Do you have any questions that you would like to ask us about our program, housing, etc?

_____

_____

_____

_____

_____