



# Mending Hearts Recovery

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## Application

*Please note: Please answer all questions open and honestly.  
False Statements on this application will render it null and void  
and you will be terminated from the program immediately.*

PLEASE PRINT

TODAY'S DATE \_\_\_\_\_

### PERSONAL INFORMATION

DOC#: \_\_\_\_\_

Full Name: \_\_\_\_\_

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

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

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

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: \_\_\_\_\_

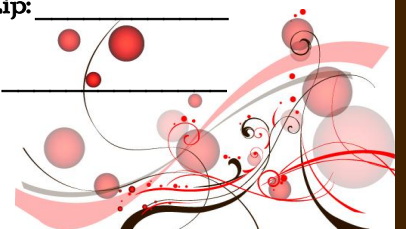
### EMERGENCY CONTACT INFORMATION

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 children to you have? \_\_\_\_\_

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      Company Name & Policy# \_\_\_\_\_
- Medicare                      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	USUAL DOSAGE	ROUTE OF DELIVERY	COMMENTS
None					
Alcohol					
Marijuana/Hashish					
Cocaine					
Amphetamines					
Methamphetamines					
Heroin					
Non-RX Methadone					
Other Opiates/Synthetics					
Barbiturates					
Tranquilizers					
Other 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:

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List any substance abuse education programs you have attended:

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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:

<u>Date</u>	<u>Charge</u>	<u>Status of Violation/Involvement</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROBATION AND PAROLE INFORMATION

<u>Name</u>	<u>Location</u>	<u>Phone Number</u>
_____	_____	_____

How long have you been or were you on probation/parole? \_\_\_\_\_

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?

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What would you like to receive from Mending Hearts Recovery Program?

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What goals would you like Mending Hearts Recovery help you achieve?

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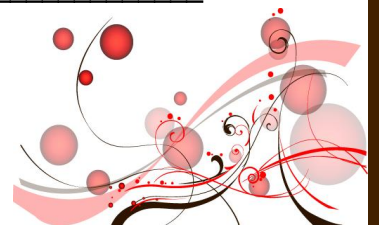
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What areas do you feel you need assistance in? Please place an X in all boxes that apply:

- 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:

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

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I certify that all information is true and correct to the best of my knowledge.

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

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

(IPO if applicable)

