Heartland Men's Recovery Center

12599 255th Street, LaBelle, MO 63447 • Admissions Phone 660-213-4553 • eFax 816-817-1802

Please read and follow these important guidelines:

1. Complete the 5-page application. Mail or fax it back to us at the address or number above, along with copies of identification types 1 & 2 (see below).
2. After sending the application, the man who wants to enroll must call the Admissions Department. Office hours are Monday through Friday, 1pm-3pm to schedule an interview.
3. If the pre-program criteria is met, the man enrolling must have the following work done:
   A. HIV Blood Test B. TB Test C. Hepatitis C Test D. Well-Check (Physical)

After we receive the test results, we can discuss an entry date.

Upon entry, please bring these two types of valid identification:

1. Photo ID (driver's license, passport, or state photo id)
2. Social Security Card
3. Birth Certificate with embossed seal

ADULT APPLICATION FORM

Name _____ Date _____

Address _____

Daytime Phone _____

Have you ever applied before? ❑ yes ❑ no Who referred you to HMRC? _____

Social Security # _____ _____ _____ Phone # _____

Driver's License # _____ Valid? ❑ yes ❑ no

Age _____ Birthdate _____ Height _____ Weight _____

High School Graduate? ❑ yes ❑ no

Occupation or Trade _____

Special Skills _____

Physical Problems _____

_____

Special Medical Needs _____

_____

Upcoming Court Dates _____

Emergency Contact

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____

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THE PROBLEM

What is your main problem, as you see it? _____

_____

What is your main problem, as others see it? _____

_____

What would improve your situation? _____

_____

Is change something you look forward to? _____

Have you ever gone to an in-house treatment facility? ❑ yes ❑ no If yes, how many? _____

Were they spiritual in any way? ❑ yes ❑ no ❑ other _____

Have you ever "honestly" considered the direction your life is headed? ❑ yes ❑ no

Which do you like the most? ❑ alcohol ❑ drugs ❑ both

Do you smoke or use tobacco? ❑ yes ❑ no If yes, would you like to stop? ❑ yes ❑ no ❑ not really

Have you ever received any form of mental health treatment? ❑ yes ❑ no If yes, please list:

DATE	CLINIC	REASON FOR TREATMENT	OUTCOME
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any special psychiatric needs? ❑ yes ❑ no

What prescription drugs are you currently taking? _____

_____

_____

Have you ever considered suicide as a possible solution for all your problems? ❑ yes ❑ no

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FAMILY MATTERS

Parents:

Name _____

Address _____

Phone _____

Would you say that you have a strong Christian background? _____

Is there anyone in your family that has experienced any of the problems that stem from alcohol or drug abuse?

_____

Have you ever been married? ❑ yes ❑ no

Wife's Name _____

Children's Names _____

Would you say that your marriage is/was based on Christian principles? _____

Do you think that God can and will repair any damaged or strained relationships? ❑ yes ❑ no

How is your prayer life? ❑ great ❑ fair ❑ poor

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Are you currently incarcerated? ❑ yes ❑ no

Have you been arrested recently? ❑ yes ❑ no If yes:

Date _____

Arrested for _____

Are any of the following pending against you? Check all that apply:

❑ Arrest Warrant ❑ Court Appearance ❑ Criminal Charges ❑ Sentencing ❑ Other

Briefly explain: _____

_____

_____

Do you have any upcoming court dates? ❑ yes ❑ no If yes, please list: _____

Are you now, or will you be under legal supervision? ❑ yes ❑ no If yes, complete the following:

❑ Probation How long?_____ ❑ Parole How long? _____

Method of Reporting_____How often? _____

List probation/parole officers:

Name _____

Address _____

Phone_____

If you are currently incarcerated, please provide a contact person in your jail:

Name _____

Phone_____

Are you legally mandated to participate in a recovery program? ❑ yes ❑ no If yes, list by whom:

_____

Would it be possible for you to have your probation transferred to this state/county? ❑ yes ❑ no

A local probation officer comes to Heartland once per month.

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Request for Release of Confidential Information

Date ..... _____

To ..... _____

Address .... _____

_____

Phone..... _____

Fax..... _____

From

Heartland Men's Recovery Center
12599 255th Street
LaBelle, MO 63447

Phone (660) 213-4553
eFax (816) 817-1802

Re: _____

_____

Heartland Men's Recovery Center (HMRC) is requesting the disclosure of information pertinent to the placement of the above person to the Recovery Center's Recovery Program. The following information is requested:

❏ Medical Reports ❏ Psychological Reports ❏ Counseling Reports

❏ Diagnostic Reports ❏ Academic Reports ❏ Education/Transcripts

❏ Social History ❏ Family History ❏ IEP's

❏ Other _____

It is understood that the information forwarded will be used only by HMRC and is confidential and may be protected by federal and state law. Any further disclosure of the forwarded information without specific consent is prohibited. The signature on this request for information document has been freely and voluntarily given.

_____ _____

Signature of Applicant Date

_____ _____

Signature of HMRC Representative Date

HMRC PREMISES IS UNDER VIDEO SURVEILLANCE.

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HMRC Physical Form

Must be filled out by a physician at the time of well-check.

A WELL-CHECK PHYSICAL IS REQUIRED IN ADDITION TO THE HMRC PHYSICAL FORM

History of Previous or Chronic Injuries:_____

_____

_____

_____

_____

Musculoskeletal Issues: _____

_____

Back/Leg/Shoulder Issues: _____

_____

Allergies (Animal, Latex, Iodine, etc.): _____

_____

Performance Requirements:

Applicant is able to work 10 consecutive hours standing on concrete, as well as working with arm above the shoulders: ❑ yes ❑ no

Physician Name (Please Print):_____

Physician Signature: _____

I hereby authorize the release of this information to HMRC:

Name (Please Print): _____

Signature: _____

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Employee Health Examination Record

To be filled out by a physician.

Employee, complete this section:

Name: _____

Birthdate: _____

Married ❑
Single ❑
Widowed ❑
Divorced ❑
Separated ❑

Notify in the case of an emergency:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Do you have any of the following?

	Yes	No		Yes	No
Operations	❑	❑	Fainting Spells	❑	❑
Fractures	❑	❑	Epilepsy	❑	❑
Head Injury	❑	❑	Mental Disease	❑	❑
Back Injury	❑	❑	Jaundice	❑	❑
Other Injuries	❑	❑	Rheumatism	❑	❑
Chronic Back Pains	❑	❑	Asthma	❑	❑
Tuberculosis	❑	❑	Sinus Trouble	❑	❑
Heart Trouble	❑	❑	Skin Disease	❑	❑
Stomach Trouble	❑	❑	Hernia	❑	❑

I have read the above and declare that I have had no injuries, illnesses, or ailments other than specifically herein noted. Any falsification or misrepresentation will be sufficient grounds for my release from employment. I am not currently receiving work related compensation.

Employee Signature: _____

Date: _____

Physician, complete this section:

Ears: _____ Lungs: _____

Eyes: _____ Abdomen: _____

Teeth: _____ Hernia: _____

Nose & Throat: _____ Extremities: _____

Skin: _____ Blood Pressure: _____

Scars: _____ Date of Last Chest X-ray: _____

Heart: _____

T-_____ P- _____ R- _____ Weight: _____ Height: _____

Free from communicable diseases: _____

Physician Signature: _____ Date: _____