

Hearland Men's Recovery Program

500 New Creation Road, Newark, MO 63458 • Admissions Phone 660-213-4553 • eFax 816-817-1802

Please read and follow these important guidelines:

1. Complete the application along with the required bloodwork containing your HIV, HEP-C, and TB results with a physical. We will also need copies of your identification containing either a valid driver's license or a state ID, and either a birth certificate with embossed seal or a social security card.
2. When this portion of the application is complete, please mail or fax the application, required bloodwork and physical, and copies of your identification back to us at the address or fax number listed above.
3. Once everything is turned in, call the admissions office between the hours of 8am-5pm Monday thru Friday to schedule a phone interview. This will complete the application process. From this point we can begin to discuss possible entry dates.
4. Upon entry, please understand that the following items will be required for admission into the program: a hard copy of a valid photo ID, a birth certificate with seal or social security card, and a \$200 program entry fee.

ADULT APPLICATION FORM

Name _____ Date _____

Address _____

Daytime Phone _____

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

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 Program
500 New Creation Road,
Newark, MO 63458
Phone (660) 213-4553
eFax (816) 817-1802*

Re: _____

Heartland Men's Recovery Program (HMRP) is requesting the disclosure of information pertinent to the placement of the above person to the Heartland 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 HMRP 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 HMRP Representative

Date

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HMRP 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 HMRP 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 HMRP:

Name (Please Print): _____

Signature: _____

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Employee Health Examination Record

To be filled out by a physician.

Employee, complete this section:

Name: _____	Married <input type="checkbox"/>
Birthdate: _____	Single <input type="checkbox"/>
	Widowed <input type="checkbox"/>
	Divorced <input type="checkbox"/>
	Separated <input type="checkbox"/>
Notify in the case of an emergency:	
Name: _____	Relationship: _____
Address: _____	Phone: _____

Do you have any of the following?		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: _____
Yes No	Yes No	
Operations <input type="checkbox"/> <input type="checkbox"/>	Fainting Spells <input type="checkbox"/> <input type="checkbox"/>	
Fractures <input type="checkbox"/> <input type="checkbox"/>	Epilepsy <input type="checkbox"/> <input type="checkbox"/>	
Head Injury <input type="checkbox"/> <input type="checkbox"/>	Mental Disease <input type="checkbox"/> <input type="checkbox"/>	
Back Injury <input type="checkbox"/> <input type="checkbox"/>	Jaundice <input type="checkbox"/> <input type="checkbox"/>	
Other Injuries <input type="checkbox"/> <input type="checkbox"/>	Rheumatism <input type="checkbox"/> <input type="checkbox"/>	
Chronic Back Pains <input type="checkbox"/> <input type="checkbox"/>	Asthma <input type="checkbox"/> <input type="checkbox"/>	
Tuberculosis <input type="checkbox"/> <input type="checkbox"/>	Sinus Trouble <input type="checkbox"/> <input type="checkbox"/>	
Heart Trouble <input type="checkbox"/> <input type="checkbox"/>	Skin Disease <input type="checkbox"/> <input type="checkbox"/>	
Stomach Trouble <input type="checkbox"/> <input type="checkbox"/>	Hernia <input type="checkbox"/> <input type="checkbox"/>	

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: _____