Application # _____
Date Received: _____
Staff Person: _____

Application-Part 1-050.1b

Our mission is to provide a sanctuary (our group home) that offers HOPE (Healing, Opportunity, Peace and Empowerment) to single women who are committed to achieving self-sufficiency.

Legal Name: Last _____ First _____MI ____

Phone #'s (home, cell, work, friend's phone etc.)	Best time to call	Ok to leave message?

Date of Birth: _____ Age_____ Race/Ethnicity: _____

Current Kansas ID or Driver's license # _____ Please bring to first appointment.

Are you homeless? _____ Do you have transportation? _____ Are you a veteran?_____

Street Address: _____ City: _____ State:_____

Who do you live with? _____

Relationship status_____

MINOR CHILDREN'S BASIC INFORMATION

Child's Legal Name	Gender	Birthdates	Where does this child live?

Legal

Do you have any pending court cases; criminal, divorce, custody, child support, lawsuits? Circle those that apply to you and explain here: _____

Note: Before being approved for residency, a background search will be conducted.

Charge/crime	Felony	Sentence	Fines	Date of completion

If you are currently on probation or parole, please fill out.

Name of court supervisor _____Address_____ Phone # _____

Is this person supportive of you applying for Mt. Hope Sanctuary? _____

SUBSTANCE ABUSE:

Note: we require random drug testing before and during residency.

Type of drug/alcohol	When did you start?	How often?	Last usage	

Have you been to an in or out patient treatment program?

Treatment Facility: _____ Treatment Date: _____ Court mandated? Y N

Treatment Facility: _____ Treatment Date: _____ Court mandated? Y N

Treatment Facility: _____ Treatment Date: _____ Court mandated? Y N

Have you ever been evaluated for mental health disorders? Y N

If so, what diagnosis was given for your mental health?

_____

_____

If you are taking any prescription drugs, over the counter, vitamins or supplements please list below.

Medication name	*Reason for med*	*Prescribing doctor*

List any contagious/infectious medical conditions: _____

Please describe your current situation. Use back of page if necessary.

Mark the "O" before each area you feel help is needed for you and your children.

O *Education/career development*: O Employment O Job Training O Education O Resume
O *Financial:* O Budgeting O Bill Paying O Increasing income O Saving
O *Mental:* O Goal setting/visualizing O planning O Legal
O *Personal growth & development:* O Mental Health O Parenting O Counseling O Relationships
O *Physical*: O Nutrition O Health exam O Dental O Vision O Hearing test O Exercise
O *Social/Emotional:* O Community service O Volunteer work
O *Spiritual:* O Value clarification & commitment O Study & Meditation O Mentor
O *Temporal:* O Housing O Transportation O Child Care O Food O Legal O Furniture or household items

COMMUNITY RESOURCES PROVIDERS

Please list any therapists, counselors, or others who are providing services to you and/or your children *It is a requirement of Mt. Hope Sanctuary that every mother with a child two years or under be on the WIC program. (e.g., WIC, DCF, CUM, Resource Council, SA/DV, Court Services, Attorneys, Mediation Services, AA, NA, Churches, other support groups etc...)

Name of provider	Service provided	Address	Phone #

What is your desired relationship with Mt. Hope Sanctuary, Inc.? Check one.

- o Resident; I would like to be considered to live at Mt. Hope home.
- o Referral; I need some help finding the right resources for my situation.

Have you received services from us before? _____ When? _____

Name of Staff who helped you? _____

Where/How did you hear about us? _____

If you have any questions about our program/intake, or do not hear from us within a week after dropping off this application, please call Julie 620-241-1993.

My signature on this application authorizes employers, Community Service Providers, and any other persons or agencies with knowledge of my circumstances to release to Mt. Hope Sanctuary any information, including confidential, needed to determine my eligibility for the Program and services of Mt. Hope Sanctuary. This release is valid from the date signed below until revoked in writing by undersigned.

By my signature, I certify that the information contained in this application is true and factual to the best of my knowledge. I understand if any false information is given, the application may be denied.

_____ _____

Signature Date

Client criteria:

1. Must accept responsibility for past, present, and future actions.
2. Must choose not to return to old associations, behaviors or lifestyles that affect your life in a negative manner.
3. Must be committed to a personalized program, which is determined based on specific needs to gain self-sufficiency.