Mustard Seed Homes
Residential Program Application

Date_____

Personal Information:

Full Name: _____ _____ _____
(First) (Middle) (Last)

Address:_____ _____ _____ _____
(Street, PO Box) (City) (State) (Zip Code)

Phone: _____ - _____ - _____ **E-mail:** _____

Date of Birth: _____**Social Security Number** _____-_____-_____

Medical Insurance Provider: _____**Number:** _____

County of Financial Responsibility: _____**Caseworker** _____

Do you have a legal guardian? Yes No **If so, list contact information under "Emergency Contact Person".**

Are you a veteran? Yes No

Present Housing Situation:

____**Live w/ Spouse**	____**Live w/ Friends**	____ **Homeless**
____**Live w/ Parents**	____**Incarcerated**	____**Live alone**
____**Live w/ a relative**	____**Treatment Facility**	____ **Other**_____

Education: HS Diploma _____ **GED**_____ **Highest Grade Completed:**_____

College (name, credits, major area of study):_____

Emergency Contact Person: (Please circle all that apply - friend family member guardian):

(Name) _____ _____
(Relationship to you)

Address:_____ _____ _____ _____
(Street, PO Box) (City) (State) (Zip Code)

Phone(s): _____**(home)**_____ **(cell)**_____ **(work)**

E-mail: _____

Secondary Emergency Contact

Name: _____ _____
(Relationship to you)

Address:_____ _____ _____ _____
(Street, PO Box) (City) (State) (Zip Code)

Phone(s): _____**(home)**_____ **(cell)**_____ **(work)**

E-mail address: _____

Family Information:

Mother: _____
(Name)

Address:_____ _____ _____ _____
(Street, PO Box) (City) (State) (Zip Code)

Phone(s): _____**(home)**_____ **(cell)** _____ **(work)**

E-mail address: _____

Father: _____
(Name)

Address:_____ _____ _____ _____
(Street, PO Box) (City) (State) (Zip Code)

Phone(s): _____**(home)**_____ **(cell)** _____ **(work)**

E-mail address: _____

Spouse: _____
(Name)

Address:_____ _____ _____ _____
(Street, PO Box) (City) (State) (Zip Code)

Phone(s): _____**(home)**_____ **(cell)** _____ **(work)**

E-mail address: _____

Children:

Name:_____ **Sex:** M F **Age:**_____ **DOB:** _____/_____/_____

Name:_____ **Sex:** M F **Age:**_____ **DOB:** _____/_____/_____

Name:_____ **Sex:** M F **Age:**_____ **DOB:** _____/_____/_____

Name:_____ **Sex:** M F **Age:**_____ **DOB:** _____/_____/_____

Are you the: **Custodial parent / Non-custodial parent** **(circle one)**

Do you have: **Supervised visitation / Non-supervised visitation (circle one)**

Employment History:

Company Name	Dates Starting & Ending	Position	Reason for leaving
_____	_____ to _____	_____	_____
_____	_____ to _____	_____	_____
_____	_____ to _____	_____	_____

Financial Situation:

Are you working? Yes No **If yes, where?** _____

Part-time: ___ Full time: ___ Hours & Days:_____

Supervisor: _____ **Phone number:**_____

Monthly Income from Job:_____

Sources of Income:

Social Security: ___Yes ___No **Monthly Income:** _____

Disability: ___Yes ___No **Monthly Income:** _____

Food Stamps: ___Yes ___No **County/State:** _____

General Assistance: ___Yes ___No **County/State:** _____

Have you applied for County Assistance? Yes No **County/State:**_____

Religion: _____

Name of Church, if applicable:_____

Address of Church _____

Name of Pastor: _____ **Phone Number:** _____

Life Story: **Write a brief biography of your life, including your spiritual experiences.**

Medical Information:

Present medical information/concerns:

_____

_____

Are you currently taking any medications? Yes No **If yes, list medications & dosage:**

_____ _____

_____ _____

Medical History: (Check all that apply to your current or past conditions)

___ADD	___Diabetes	___High Blood Pressure	___Physical Abuse
___ADHD	___Drug Abuse	___HIV Virus	___Rape
___Alcohol Abuse	___Anorexia	___Flashbacks	___Asthma
___Back Problems	___Bipolar	___Bulimia	___Depression
___Head Trauma	___OCD	___Hearing Voices	___Heart Condition
___Hepatitis (type?_____)	___Insomnia	___Mental Illness	___MPD
___Nervous Condition	___Paranoia	___Homicidal Thoughts	___VD
___TB	___Seizures	___Sexual Abuse	___Schizophrenia
___Respiratory Problems	___Suicidal Thoughts	___Suicide Attempts	___Other _____

Special Needs:

Do you have any type of disability? Yes No **Type:**_____

Do you require a special diet? Yes No **Type:**_____

Do you have any medical restrictions? Yes No **Type**_____

Do you have any allergies? Yes No **Type:** _____

Do you have any chronic conditions Yes No **Type:** _____

Do you have any other type of special needs? Yes No **Type:**_____

Check any behaviors listed below with which you struggle:

_____Hostility	_____Violence
_____Manipulative	_____Verbal abuse
_____Cutting/Burning	_____Stealing
_____Co-Dependency	_____Revengeful
_____Defensive	_____Irresponsible
_____Withdrawn	_____Dishonesty/Lying
_____Aggressive	_____Attempted Suicide
_____Perfectionist	_____Overeating
_____Compulsive	_____Anorexia/Bulimia
_____Overly dramatic	_____Pornography
_____Extremely independent	_____Substance abuse

Name of medical doctor: _____

Name of clinic:_____ **Phone:**_____

Address:_____ _____ _____ _____
(Street, PO Box) **(City)** **(State)** **(Zip Code)**

Name of mental health provider: _____

Name of clinic:_____ **Phone:** _____

Address:_____ _____ _____ _____
(Street, PO Box) **(City)** **(State)** **(Zip Code)**

Chemical Dependency:

Chemical/drug(s) of choice: _____

Date of last use: _____ **How often did you use:**_____

Do you have a current desire to use? Yes No

Longest period of sobriety: _____

Previous or current treatment program(s). List program name & city:

_____

_____

_____

_____

_____

Contact person at last treatment program: _____

Phone Number_____

Relapse pattern: _____

Do you have a relapse prevention program? Yes No **If yes, what is it?**

_____

<u>Substance Abuse</u>: (Check all that apply with date last used – month & year)

_____**Alcohol**	_____**Crack**	_____**Huffing/Sniffing**
_____**Mushrooms**	_____**Cocaine**	_____**Marijuana**
_____**Ecstasy**	_____**LSD**	_____**PCP**
_____**Barbiturates**	_____**Meth**	_____**GHB/MDM**
_____**Amphetamines**	_____**Heroin**	_____**Other**_____
_____**Prescription Drugs**	_____**Over the counter drugs**	

Do you use tobacco? Yes No **Type:**_____

Legal Situation:

Current Legal Status

Are you currently on probation? Yes No **State/ County**_____

Name of Probation Officer _____

Any Court Cases Pending?

When_____ **State/County**_____

Any warrants out for your arrest? Yes No **State/County**_____

Under Investigation? Yes No **State/County**_____

Any Lawsuits? Yes No **State/County**_____

Ordered to do Community Service? Yes No **State/County**_____

Past Legal Status - Have you ever been:

Arrested? **Year**_____ **State/County**_____

On Probation? **Year**_____ **State/County**_____

Juvenile Detention Center? **Year**_____ **State/County**_____

Sentenced to Jail? **Year**_____ **State/County**_____

In Prison? **Year** _____ **State/County**_____

Criminal Activity: (Check all with which you have been involved.)

___Aiding & Abetting	___Probation Violation	___Prostitution
___Rape/Attempted Rape	___Sex w/a minor	___Stalking
___Truancy	___Vandalism	___Order of Protection
___Violation of Order of Protection	___Driving w/out a license	___DUI
	___Theft/ Shoplifting	___DWI
___Drug Manufacturing	___Drug Possession	___Assault
___Manslaughter/Murder	___Felony Conviction	___Escape from custody
___Fraud	___Kidnapping	___Child Abuse/Neglect
___Child Pornography	___Disorderly conduct	___Terrorist Threat
___Harassment	___Larceny	___Armed Robbery
___Attempted Assault	___Attempted Murder	___Arson
___Attempted Theft	___Criminal Sexual Conduct	___Domestic Violence
___Concealed Weapon	___Use of firearm in a crime	___Embezzlement
___Fleeing or Eluding Police	___Incest	___Possession of stolen property
___Leaving the scene of an accident	___Other _____	

Why are you interested in being a part of the Mustard Seed Homes Program?

_____

_____

_____

Who has encouraged you to become a part of Mustard Seed Homes?

_____

_____

When the required documents have been completed and returned to the Clear Waters Life Center the program director and MSH committee will review your application and will contact you regarding your acceptance/non-acceptance into the MSH Adult Equipping Program. Thank you for your interest in our program and a positive lifestyle choice.

I authorize Mustard Seed Homes to contact any individuals named in this and to obtain a criminal background check.

_____ _____

Signature **Date**

Clear Waters Life Center
PO Box 155, 256 2nd Ave., SW
Clearbrook, M. 56634
Phone: 218 776-2789 Fax: 218 776-2786
cwlc@gvtel.com
www.mustardseedhomes.org

Authorization for Release of Information

Name: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip:** _____

Phone Number: _____

☐ **I authorize the** _____
to release information to:

Clear Waters Life Center
Name
PO Box 155, 256 2nd Ave., SW
Address
Clearbrook, MN 56634
City, State, Zip Code
218-776-2789
Phone #

☐ **I authorize the**_____
to obtain information from:

_____
Name of Provider or Facility
_____
Address
_____
City, State, Zip Code
_____
Phone #

PURPOSE OF THIS REQUEST: (check one) ☐ **Healthcare** ☐ **Personal** ☐ **Other**

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments** ☐ **Progress Notes** ☐ **Laboratory Test Results:** _____

☐ **Diagnostic Impression** ☐ **Discharge Summary** ☐ **Treatment Plans**

☐ **Treatment Summary**

☐ **Other: (**please describe) Attendance_____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

☐ When the requested information has been sent/received.
☐ 90 days from this date. ☐ Other: _____

Signature: _____ Date: _____