

Men's Life Recovery Application
 Stage One Recovery – Rockford Rescue Mission Ministries

Rockford Rescue Mission 715 W. State Street Rockford, IL 61102 815-316-4168 Fax: 815-965-0033

Date: _____

IDENTIFICATION

Name
(Last) (First) (M)
Contact number:
Alias/Nicknames:

DOB: Month Day 19
SSN: XXX-XX- (Last 4 ONLY)
DL: ___ Yes ___ No #
State ID: ___ Yes ___ No
SS Card? ___ Yes ___ No Birth Cert. ___ Yes ___ No
US Citizen? ___ Yes ___ No Veteran? ___ Yes ___ No
Race: ___ African American ___ Multi Cultural ___ Caucasian ___ India ___ Asian ___ Indian American ___ Other: _____
Ethnicity: ___ Non Hispanic ___ Hispanic
Military Branch:

HOUSING

Homeless? ___ Yes ___ No How Long?
Reason?
Hometown? County?
Is it a result of Domestic Violence? ___ Yes ___ No
How long in Winnebago County?
Number of times homeless?
Address (if not homeless)
Are you banned from any shelters? ___ Yes ___ No

ID's VERIFIED BY:
BACKGROUND CHECK BY:
SEX OFFENDER CHECK BY:
DATE: Attach Results

RELATIONSHIPS

Marital Status: ___ Married ___ Divorced ___ Single ___ Widowed Partner's name?
Children? ___ Yes ___ No How many? Names & ages (list)
Who cares for your children?
How often do you see them? When did you last see them?
Emerg. Contact: Name Phone Number Relationship

FINANCIAL

Monthly Income: \$	Sources: ___ Unemployment ___ SSI/SSDI ___ Pension ___ Other	Amount \$
Rep Payee:		Amount \$
Link Card? ___ Yes ___ No Monthly Amount \$		Amount \$
Debts? ___ Yes ___ No	List:	

For Office Use: Name: _____ Date: _____

Case Manager: _____ Extension # _____ Dept. _____

HEALTH

General Health <input type="checkbox"/> Good <input type="checkbox"/> Poor	Medical Card <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No
Current Problem?	Describe:
Doctor Name:	Scheduled Appointments? (list)
Provider Name:	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Prescription Meds? <input type="checkbox"/> Yes <input type="checkbox"/> No	List Meds:
Date of Last Physical:	
Please circle any chronic illnesses that you have:	
STI/PID	Asthma
Eye Disease	Diabetes
Emphysema	HIV/AIDS
Ulcers	Lupus
Stroke	Bronchitis
Gout	Allergies
CHF	Sleep Apnea
	Tuberculosis
	Cancer: (specify) _____
	Sickle Cell Disease
	Epilepsy/Seizure Disorder
	Pulmonary Disorder
	High Blood Pressure
	Multiple Sclerosis
	Rheumatoid Arthritis
	Ulcerative Colitis
	Hepatitis
	Surgeries: _____
	Cardiac Failure
	Glaucoma
	Crohn's Disease
	Cirrhosis
	Pneumonia
	Osteoarthritis
	Kidney Disease
	GRAVIDA/PARA

MENTAL HEALTH

Mental Health Issues? <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis:	Please circle any chronic illnesses that you have:
Past Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis:	Depression
Current Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:	PTSD
Taking Mental Health Meds? <input type="checkbox"/> Yes <input type="checkbox"/> No	List Meds:	Anxiety
Using as Prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Bipolar
MHP Name:	Appointments? (list)	Schizophrenia
Diagnosed Mental Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis:	Other:
Family History of Mental Health Issues?	Describe:	

ADDICTIONS

Date Last used Alcohol:	What?
Date Last used Drugs:	What?
Drug of Choice:	List other Drugs Used:
Frequency of Use?	
Past Treatment or Detox? <input type="checkbox"/> Yes <input type="checkbox"/> No	List Places and Approximate Dates
How Many Times?	
Attend AA? <input type="checkbox"/> Yes <input type="checkbox"/> No	How Often? AA Sponsor? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Support Group? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where? How often?

LEGAL ISSUES

Current Legal Issues? <input type="checkbox"/> Yes <input type="checkbox"/> No	Charges?	Court Dates:
On Parole? <input type="checkbox"/> Yes <input type="checkbox"/> No	Termination Date:	Parole Agent:
Paroled to Rockford? <input type="checkbox"/> Yes <input type="checkbox"/> No	Paroled From:	
On Probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Termination Date:	Prob. Officer:
Type of Prob.?		
Other Criminal History? <input type="checkbox"/> Yes <input type="checkbox"/> No	List Previous Offenses, Sentence, Time Served, Where Served & Dates:	
SEX OFFENDER? <input type="checkbox"/> Yes <input type="checkbox"/> No		
ARSONIST? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Winnebago County Offender <input type="checkbox"/> Yes <input type="checkbox"/> No		
Master ID #:		

EMPLOYMENT

<input type="checkbox"/> Employed	Where?
<input type="checkbox"/> Unemployed	When last employed?
Occupation/Skills:	

EDUCATION

Last Grade Completed:	Year Completed:	<input type="checkbox"/> Diploma <input type="checkbox"/> GED <input type="checkbox"/> Certificate
Degree:	Functional Reader? <input type="checkbox"/> Yes <input type="checkbox"/> No	/ Writer? <input type="checkbox"/> Yes <input type="checkbox"/> No

TRANSPORTATION & CLOTHING

<input type="checkbox"/> Own Vehicle <input type="checkbox"/> Bus <input type="checkbox"/> Walk <input type="checkbox"/> Bicycle <input type="checkbox"/> Other	Vehicle Description: License Plate Number: CLOTHING NEEDS:
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SPIRITUAL CONDITION

<input type="checkbox"/> Christian <input type="checkbox"/> Other:	Describe your spiritual condition:
Relationship with Jesus Christ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
What do you believe about God?	
Church affiliation:	

I, (print) _____, do hereby certify that the above information is true and accurate to the best of my ability. I understand false information may be cause for my immediate dismissal from the program.

Signature _____ Date _____

Witness _____ Date _____

