



# Restoration of Hope Project

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## Application for Mommy & Me Program

Today's Date: \_\_\_\_\_

### **Mother's Information:**

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Other Names Used: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Race: \_\_\_\_\_ Distinguishing marks (tattoos, scars): \_\_\_\_\_

Have you ever applied to or lived at Restoration of Hope Project Recovery Housing? YES ☐ NO ☐

How did you hear about our program/Referral Source: \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_ Telephone: \_\_\_\_\_

Are you working with any agency for substance use treatment or mental health (Burrell, Preferred Family Healthcare, Higher Ground, Heartland, etc.): \_\_\_\_\_

If so, list caseworker or contact person: \_\_\_\_\_

Are you: Married ☐ Divorced/Separated ☐ Widowed ☐ Single/Never Married ☐ Other ☐ \_\_\_\_\_

Are you in a relationship: Yes ☐ No ☐ If yes, Spouse/Significant other's name: \_\_\_\_\_

Is there a pending DFS Case: Yes ☐ No ☐ If yes, please list caseworker and agency: \_\_\_\_\_

Is there a Guardian Ad Litem assigned to your child(ren): Yes ☐ No ☐ If yes, please fill out their contact

information: Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

### **Legal:**

Please list all prior and pending charges/convictions. Please include where the charge took place and the year:

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Please list your DOC Number if applicable: \_\_\_\_\_

Are you on any kind of supervision (probation, parole, pretrial services, etc.): Yes ☐ No ☐

If yes, please list officer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do you have an attorney: Yes ☐ No ☐ If yes, please list: Name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Have you ever been charged or convicted of arson: Yes ☐ No ☐

Have you ever been charged or convicted with cruelty to animals: Yes ☐ No ☐

Have you ever been charged or convicted of a violent crime, including assault or domestic assault: Yes ☐ No ☐

Have you ever been charged or convicted of a sexual crime: Yes ☐ No ☐

Have you ever been charged or convicted of child endangerment: Yes ☐ No ☐

If you listed yes to any of these, please explain:

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Is there currently a 'no contact' order or ex parte in place: Yes ☐ No ☐ If yes, list name and any additional information related to this: \_\_\_\_\_

Please list any future court dates or appearances: \_\_\_\_\_

Do you have any active warrants we can assist you with: Yes ☐ No ☐ If yes, where: \_\_\_\_\_

**Substance Use History:**

What substances do you struggle with the most: \_\_\_\_\_

When was the date of your last use: \_\_\_\_\_

Age of first use: \_\_\_\_\_

Check all substances you have used in the past:

Alcohol ☐ Heroin/Fentanyl ☐ Methamphetamine ☐ Prescription Pain Medication ☐

Benzodiazepines ☐ Cocaine ☐ Marijuana ☐ LSD/Hallucinogens ☐ Bath Salts ☐ K2/Synthetics ☐

Other ☐ Please list: \_\_\_\_\_

Describe any periods you have been able to remain abstinent. What did you do to achieve/maintain this?

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What are some common triggers for you? Think about any reason that caused you to continue to use or go back to substance use:

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Have you ever lived in a recovery home before? Yes ☐ No ☐ If yes, please answer the following:

❖ Where/Name of Program: \_\_\_\_\_ When: \_\_\_\_\_

How long were you there: \_\_\_\_\_

Why did you leave: \_\_\_\_\_

Did you complete/graduate: Yes ☐ No ☐

❖ Where/Name of Program: \_\_\_\_\_ When: \_\_\_\_\_

How long were you there: \_\_\_\_\_

Why did you leave: \_\_\_\_\_

Did you complete/graduate: Yes ☐ No ☐

On a scale of 1 to 10, how serious of a problem do you think you have with drugs and/or alcohol?

(Circle One) **No problem** 1 2 3 4 5 6 7 8 9 10 **Very Serious**

**Substance Use/ Mental Health Treatment:**

Do you currently attend AA: Yes ☐ No ☐ If yes, where: \_\_\_\_\_

Do you currently attend NA: Yes ☐ No ☐ If yes, where: \_\_\_\_\_

Do you currently attend one on one Therapy or Counseling: Yes ☐ No ☐ If yes, where: \_\_\_\_\_

Do you currently attend support groups related to your recovery: Yes ☐ No ☐ If yes, where: \_\_\_\_\_

Do you currently attend education classes related to your recovery: Yes ☐ No ☐ If yes, where: \_\_\_\_\_

Have you completed a parenting education class: Yes ☐ No ☐ If yes, where: \_\_\_\_\_

Are you interested in attending treatment for your substance use disorder: Yes ☐ No ☐

Are you interested in attending treatment for a mental health disorder: Yes ☐ No ☐

Are you interested in attending a parenting class: Yes ☐ No ☐

How motivated are you to attend treatment:

(Circle One) **No problem** 1 2 3 4 5 6 7 8 9 10 **Very Serious**

**Employment:**

Are you currently employed: Yes ☐ No ☐ If so, where: \_\_\_\_\_ How long: \_\_\_\_\_

If no, do you have any existing barrier to employment: \_\_\_\_\_

Do you have:

Driver's License: Yes ☐ No ☐ Social Security Card: Yes ☐ No ☐

State Identification: Yes ☐ No ☐ Birth Certificate: Yes ☐ No ☐

Do you have your own vehicle: Yes ☐ No ☐ If yes, do you have insurance: Yes ☐ No ☐

**Education:**

Highest Education Level:

High School Diploma ☐ GED ☐ Some College ☐ College Degree ☐ Other ☐ \_\_\_\_\_

Name of last school attended: \_\_\_\_\_

Are you interested in going back to school or furthering your education: Yes ☐ No ☐

**Physical Health Information:**

Please list any physical health problems:

\_\_\_\_\_

Do you require any treatment or accommodations in regard to your physical health: Yes ☐ No ☐ If yes, please explain: \_\_\_\_\_

Please list any known allergies and reactions:

\_\_\_\_\_

Can you:

Go up and down stairs: Yes ☐ No ☐

Complete your daily, assigned house chore: Yes ☐ No ☐

Get to any appointments you may have via bus if necessary: Yes ☐ No ☐

Do you have a history of:

Dental problems: Yes ☐ No ☐ \_\_\_\_\_

Seizures: Yes ☐ No ☐ \_\_\_\_\_

Hepatitis: Yes ☐ No ☐ \_\_\_\_\_

Heart condition: Yes ☐ No ☐ \_\_\_\_\_

Diabetes: Yes ☐ No ☐ \_\_\_\_\_

Other: Yes ☐ No ☐ \_\_\_\_\_

Are you currently on any medications for your physical health: Yes ☐ No ☐ If yes, please list all physical health medications, dosage, and frequency:

\_\_\_\_\_  
\_\_\_\_\_

Do you have a primary care physician: Yes ☐ No ☐ Name of doctor: \_\_\_\_\_

In the event of emergency, do you have a hospital preference: \_\_\_\_\_

Other information regarding your physical health:

\_\_\_\_\_

### **Mental Health Information:**

Please list any mental health diagnoses:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized in a mental health unit: Yes ☐ No ☐ If yes, please list dates, reasons, and outcomes:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever heard voices that were NOT drug induced: Yes ☐ No ☐

If yes, list date of last incident: \_\_\_\_\_

Have you ever experienced visual hallucinations that were NOT drug induced: Yes ☐ No ☐

If yes, list date of last incident: \_\_\_\_\_

Have you ever attempted suicide: Yes ☐ No ☐ If yes, please list date(s): \_\_\_\_\_

Have you ever been diagnosed with a learning disability: Yes ☐ No ☐

Do you need assistance with reading: Yes ☐ No ☐

Do you need assistance with writing: Yes ☐ No ☐

Have you ever been diagnosed with autism: Yes ☐ No ☐

**Children Information:**

**(Child 1)** Full Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Where is this child currently staying: \_\_\_\_\_

Does this child have any allergies: Yes ☐ No ☐ Please explain:

\_\_\_\_\_

Does this child have any mental health diagnosis: Yes ☐ No ☐ Please explain:

\_\_\_\_\_

Does this child have any special or physical health needs: Yes ☐ No ☐ Please explain:

\_\_\_\_\_

Is this child on any medications: Yes ☐ No ☐ Please list medication, dosage, and frequency:

\_\_\_\_\_

Childs Primary Care Physician (Name/hospital/phone number):

\_\_\_\_\_

Preferred hospital in the event of emergency: \_\_\_\_\_

Does this child receive any financial assistance: Medicaid ☐ Food Stamps ☐ WIC ☐ Other: \_\_\_\_\_

Please list any items or assistance this child may need (diapers, clothing, formula, car seat, Medicaid, WIC, etc.): \_\_\_\_\_

Does the mother have: Visits ☐ Custody ☐ Other ☐ Please explain:

\_\_\_\_\_

Biological Fathers Name: \_\_\_\_\_ Age: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Unknown: ☐

Adress: \_\_\_\_\_ Unknown: ☐

Does the father have: Visits ☐ Custody ☐ Other ☐ Please explain:

\_\_\_\_\_

Is there a child support order in place for this child: Yes ☐ No ☐ If so, how much and by who:

\_\_\_\_\_

Is there anything about this child or the situation that you think we should know:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If accepted, will this child be staying with you in the Mommy and Me program: Yes ☐ No ☐

**(Child 2)** Full Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Where is this child currently staying: \_\_\_\_\_

Does this child have any allergies: Yes ☐ No ☐ Please explain:

\_\_\_\_\_

Does this child have any mental health diagnosis: Yes ☐ No ☐ Please explain:

\_\_\_\_\_

Does this child have any special or physical health needs: Yes ☐ No ☐ Please explain:

\_\_\_\_\_

Is this child on any medications: Yes ☐ No ☐ Please list medication, dosage, and frequency:

\_\_\_\_\_

Childs Primary Care Physician (Name/hospital/phone number):

\_\_\_\_\_

Preferred hospital in the event of emergency: \_\_\_\_\_

Does this child receive any financial assistance: Medicaid ☐ Food Stamps ☐ WIC ☐ Other: \_\_\_\_\_

Please list any items or assistance this child may need (diapers, clothing, formula, car seat, Medicaid, WIC, etc.): \_\_\_\_\_

Does the mother have: Visits ☐ Custody ☐ Other ☐ Please explain:

\_\_\_\_\_

\_\_\_\_\_

Biological Fathers Name: \_\_\_\_\_ Age: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Unknown: ☐

Address: \_\_\_\_\_ Unknown: ☐

Does the father have: Visits ☐ Custody ☐ Other ☐ Please explain:

\_\_\_\_\_

Is there a child support order in place for this child: Yes ☐ No ☐ If so, how much and by who:

\_\_\_\_\_

Is there anything about this child or the situation that you think we should know:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If accepted, will this child be staying with you in the Mommy and Me program: Yes ☐ No ☐

**(Child 3)** Full Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Where is this child currently staying: \_\_\_\_\_

Does this child have any allergies: Yes ☐ No ☐ Please explain:

\_\_\_\_\_

Does this child have any mental health diagnosis: Yes ☐ No ☐ Please explain:

\_\_\_\_\_

Does this child have any special or physical health needs: Yes ☐ No ☐ Please explain:

\_\_\_\_\_

Is this child on any medications: Yes ☐ No ☐ Please list medication, dosage, and frequency:

\_\_\_\_\_

Childs Primary Care Physician (Name/hospital/phone number):

\_\_\_\_\_

Preferred hospital in the event of emergency: \_\_\_\_\_

Does this child receive any financial assistance: Medicaid ☐ Food Stamps ☐ WIC ☐ Other: \_\_\_\_\_

Please list any items or assistance this child may need (diapers, clothing, formula, car seat, Medicaid, WIC, etc.): \_\_\_\_\_

Does the mother have: Visits ☐ Custody ☐ Other ☐ Please explain:

\_\_\_\_\_

\_\_\_\_\_

Biological Fathers Name: \_\_\_\_\_ Age: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Unknown: ☐

Address: \_\_\_\_\_ Unknown: ☐

Does the father have: Visits ☐ Custody ☐ Other ☐ Please explain:

\_\_\_\_\_

Is there a child support order in place for this child: Yes ☐ No ☐ If so, how much and by who:

\_\_\_\_\_

Is there anything about this child or the situation that you think we should know:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If accepted, will this child be staying with you in the Mommy and Me program: Yes ☐ No ☐

**Please answer the following, include as much information as possible:**

Please tell us about yourself, your child(ren), and your situation:

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What arrangements are you prepared to make while you are at work in terms of childcare:

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Please explain what you have achieved in recovery thus far:

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While being in recovery, what are some things you have learned about yourself:

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Who has supported you in your recovery and how:

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In addition to your children, what else keeps you motivated:

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What are you still hoping to achieve:

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What barriers and obstacles are you trying to overcome:

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Please explain how the Mommy and Me Program can best assist you:

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In the event of an emergency (ie: hospital), what is your plan for your child(ren):

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In the event of a relapse, what is your plan for continuing your recovery:

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Failure to maintain sobriety will result in immediate dismissal from the Mommy and Me Program. What do you plan on doing to continue and support your ongoing recovery program:

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Please list three goals you are working towards accomplishing in the next year, and your plan to achieve them:

Goal 1:

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Goal 2:

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Goal 3:

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Did you receive assistance in filling out this application? Yes ☐ No ☐

If yes, name of person who assisted: \_\_\_\_\_

I, \_\_\_\_\_, affirm that my answers and information provided by me in this application are true and accurate. I understand that if I am accepted, any misinformation and/or dishonest answer may be grounds for denial or dismissal.