

Living Water Recovery Center Assessment Application

Date: _____ Phone Number (870) 523-8413 Fax Number (870) 217-0912 Mailing Address: P.O. Box 885 Newport, AR 72112

#1 Have you done an assessment with us before? _____ When? _____ (If Yes, look in file cabinet for assessment)

#2 Where would you be coming from? Home Hospital Jail (Facility Name) _____ If coming from jail once you have been released you must come straight here.

#3 PNS is a 9 month, faith based, spiritual boot camp program.

#4 PNS allows tobacco products only. NO VAPES! (All tobacco must come through the office)

* There is a 1-month Blackout. No visits, mail, or phone calls during that time. You may only receive mail during this time. Are you okay with this? _____

#5 May be eligible for a phone at 4months with good behavior

#6 Are you physically and mentally able to do chores and 40 hours a week of volunteer work for PNS? _____ #7 Have you have been to prison? Yes/No #8 How many times? _____

#9 Have you ever been charged or convicted of a sexual offense Yes/No Violent crime Yes/No If yes; what charge? _____

#10 Do you have any medical problems? List them: _____ #11 Have you ever been diagnosed with a mental illness? _____

#12 How many time have you been to the hospital in the last year? _____

#13 Are you taking any medications? List them _____

If yes, do you have your medication? _____ (You must bring your medications in with you) Do you have insurance for your medical needs? YES or NO

Any medication that can be abused, is narcotic, a sedative, can alter your mood or can get you high will not be allowed. Are you willing to voluntarily stop taking any medication that falls into the previously mentioned categories? _____

First Name _____ M.I. _____ Last Name _____ Date of Birth ____/____/____

Phone: _____ City: _____ County: _____ State: _____

Female Male Race _____ Age _____ Height _____ Weight _____ Do You Have Active Driver's License? _____

Do you have any upcoming court dates? (When?) _____ District Or Circuit County? _____

What are your charges? _____

Are you on probation/Parole? (Circle One) Felony -Misdemeanor- Juvenile Officer Name: _____ Phone#: _____ County: _____

Do you have a lawyer? Yes/No If yes; is your lawyer court appointed? Yes/No Please state name and phone number: _____

Do you know anyone or have a relative in our program? _____ Why do you want to enter program? Drugs Alcohol Depression Homeless
(If Drugs What Type?) _____

You will not receive a certificate of completion until you have successfully completed the program. Sexual orientation: Straight Gay Lesbian Bisexual

Are you pregnant? Yes OR No If yes how many weeks are you? _____

If you have a child /children will they be coming with you? _____ Are they in DHS custody? _____ # of kids _____

If yes then provide DHS caseworkers name, county and phone number _____

* When would you like to come into the facility? _____ Your Signature _____ Interview Form done by _____

Your assessment will be reviewed, and someone will contact you to advise you if you are accepted.

STAFF USE ONLY

Kids Assessment Application

Phone Number (870) 523-8413 Fax Number (870) 217-0912 Mailing Address: P.O. Box 885 Newport, AR 72112

Date: _____

#1 Do the children live with you? _____

#2 Child's Name _____ #3 Child's Age _____ D.O.B. _____ Male Female

#4 Do they have any medical problems? List them: _____ #5 Have they ever been diagnosed with a mental illness? _____

#6 Are they taking any medications? List them _____

#7 If yes, do you have their medication? _____ (You must bring child's medications in with you) #8 Does the child have insurance for medical needs? YES or NO

#9 Do the children attend school? _____ #10 What grade? _____ #11 What school do they currently attend? _____

Insurance? Yes or No Insurance # _____ Social Security Number _____

#12 Child's Name _____ #13 Child's Age _____ D.O.B. _____ Male Female

#14 Do they have any medical problems? List them: _____ #15 Have they ever been diagnosed with a mental illness? _____

#16 Are they taking any medications? List them _____

#17 If yes, do you have their medication? _____ (You must bring child's medications in with you) #18 Does the child have insurance for medical needs? YES or NO

#19 Do the children attend school? _____ #20 What grade? _____ #21 What school do they currently attend? _____

Insurance? Yes or No Insurance # _____ Social Security Number _____

#22 Child's Name _____ #23 Child's Age _____ D.O.B. _____ Male Female

#24 Do they have any medical problems? List them: _____ #25 Have they ever been diagnosed with a mental illness? _____

#26 Are they taking any medications? List them _____

#27 If yes, do you have their medication? _____ (You must bring child's medications in with you) #28 Does the child have insurance for medical needs? YES or NO

#29 Do the children attend school? _____ #30 What grade? _____ #31 What school do they currently attend? _____

Insurance? Yes or No Insurance # _____ Social Security Number _____

#32 Do the children need clothes or shoes?

*Children will attend Cedar Ridge Schools

*All clients and children will attend church services at New Life Church every Wednesday evening and Sunday morning. Clients and children will also attend life skills classes every evening. Church services and life skills classes are a mandatory requirement of this program.