



## TOGETHER PROGRAM APPLICATION

Please answer all questions completely. All information is confidential.

### I. Identifying Information

Date of Application: \_\_\_\_\_ Name (First, MI, Last): \_\_\_\_\_

Maiden Name: \_\_\_\_\_ Any other last names you have gone by: \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Phone #: \_\_\_\_\_ TX Driver's license #: \_\_\_\_\_

Cell #: \_\_\_\_\_ Wk #: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Person referring you to Arms of Hope: \_\_\_\_\_

Relationship to referring person: \_\_\_\_\_ Phone: \_\_\_\_\_

What is your religious preference? \_\_\_\_\_

Briefly describe your religious beliefs: \_\_\_\_\_

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

If referred by a church, please list the name of referring church: \_\_\_\_\_



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List previous addresses beginning with the most recent:

Address	Dates	Reason for Moving

If Arms of Hope were unable to reach you at above phone, is there an alternate number in which you can be reached? \_\_\_\_\_

**II. Marital Status**

\_\_\_\_\_ Married      \_\_\_\_\_ Divorced      \_\_\_\_\_ Never Married

(Ex)Husband's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Describe your current relationship with your (ex)husband: \_\_\_\_\_

\_\_\_\_\_

List all previous marriages:

Name	Date of Marriage	Date of Divorce

(Ex) Boyfriend's name: \_\_\_\_\_ Age: \_\_\_\_\_ Describe your current relationship with your boyfriend: \_\_\_\_\_

\_\_\_\_\_

**III. Children**

If necessary, use the back of the page.

Child's Name	Sex	DOB	Age	Grade	Father's name

Do you have other children not listed? \_\_\_\_\_ Explain: \_\_\_\_\_

Are you currently pregnant? \_\_\_\_\_ Due Date: \_\_\_\_\_

Do you have legal custody of each of your children? \_\_\_\_\_ If not, explain: \_\_\_\_\_

Do you or your children have any existing illnesses? \_\_\_\_\_

Please list **all** medications that you or your children currently take. \_\_\_\_\_

Have you or any of your children ever:

been prescribed an anti-depressant, anti-anxiety or any other psychotropic medication? No \_\_\_ Yes \_\_\_ If

yes, name of medicine and dosage: \_\_\_\_\_

attempted suicide or had any kind of suicidal thoughts? If so, please explain: \_\_\_\_\_

had previous serious illness? \_\_\_\_\_

been hospitalized in past 12 months? \_\_\_\_\_

List any allergies: \_\_\_\_\_

Do you or your children have any history of fire setting, aggressive behavior or cruelty to animals?

\_\_\_\_\_ Yes \_\_\_\_\_ No If yes explain: \_\_\_\_\_

Have you ever had any involvement with Child Protective Services (CPS)? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, please list date(s) and circumstances leading to the referrals.

Describe your relationship with your children: \_\_\_\_\_

Describe your children's relationship with their father: \_\_\_\_\_

Describe your children's relationship with their grandparents: \_\_\_\_\_

Describe how your children get along with friends and teachers at school: \_\_\_\_\_

Describe each of your children's personality and behavior: \_\_\_\_\_

Are your children victims of physical or sexual abuse? \_\_\_\_\_ Explain: \_\_\_\_\_

How do your children feel about the idea of moving to an Arms of Hope Campus? \_\_\_\_\_

**IV. Applicants Family Information**

Your Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Father's Contact Number(s): \_\_\_\_\_

Your Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Mother's Contact Number(s): \_\_\_\_\_

List names of your siblings, address & phone #: \_\_\_\_\_

Describe your relationship with your parents: \_\_\_\_\_

Other Supportive Relatives

Relationship	Name	Describe Relationship

List other individuals or agencies that are familiar with your situation:

Name/Agency	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

**V. Personal Information**

Have you ever used drugs? Yes \_\_\_\_\_ No \_\_\_\_\_

List type and how often: \_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you drink? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how often? \_\_\_\_\_

Are you currently on probation? \_\_\_\_\_ If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had a psychological evaluation? \_\_\_\_\_ Date completed: \_\_\_\_\_

Who conducted the psychological evaluation? \_\_\_\_\_

Have you and/or your children been in a psychiatric hospital? If yes, list dates and reason for hospitalization. \_\_\_\_\_  
\_\_\_\_\_

Have you ever lived in a shelter? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when and where: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been in counseling? \_\_\_\_\_ Dates: \_\_\_\_\_

Have you ever been physically abused? \_\_\_\_\_ By whom? \_\_\_\_\_

Briefly explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been sexually abused? \_\_\_\_\_ By whom? \_\_\_\_\_

Briefly explain: \_\_\_\_\_

What are your special interests and abilities? \_\_\_\_\_

Explain your circumstances: \_\_\_\_\_

What do you want to accomplish by enrolling in the Together Program? \_\_\_\_\_

**VI. Education**

Last grade in school completed: \_\_\_\_\_

Do you have a High School diploma \_\_\_\_\_ or GED \_\_\_\_\_

Describe any other job training you have completed: \_\_\_\_\_

Describe educational goals: \_\_\_\_\_

Have you received any loans for education at any time? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Are you default on any loan? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

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

**VII. Work History**

List employment, beginning with most recent:

Business name and address: \_\_\_\_\_

\_\_\_\_\_

Supervisor: \_\_\_\_\_ Dates Employed: \_\_\_\_\_

Position: \_\_\_\_\_ Hourly Wage: \_\_\_\_\_

Monthly Pay: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

\_\_\_\_\_

Business name and address: \_\_\_\_\_

\_\_\_\_\_

Supervisor: \_\_\_\_\_ Dates Employed: \_\_\_\_\_

Position: \_\_\_\_\_ Hourly Wage: \_\_\_\_\_

Monthly Pay: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

\_\_\_\_\_

What are your employment goals? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**VIII. References**

Employer Reference:

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

Business name and address: \_\_\_\_\_

Family Member Reference:

Name: \_\_\_\_\_

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

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Friend Reference

Name: \_\_\_\_\_

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

Address: \_\_\_\_\_

**IX. Transportation**

Do you have a car? \_\_\_\_\_ Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

License plate #: \_\_\_\_\_ Value: \_\_\_\_\_

Running Condition: \_\_\_\_\_

Do you have car insurance? \_\_\_\_\_ Do you have a valid Texas driver's license? \_\_\_\_\_

If you do not have a car, what are your plans for transportation? \_\_\_\_\_

Do you have medical insurance? \_\_\_\_\_ If yes, with whom: \_\_\_\_\_

Do you receive Medicaid Benefits? \_\_\_\_\_ Do you receive WIC assistance? \_\_\_\_\_

Do you receive social security benefits? \_\_\_\_\_ If yes, what is the amount? \_\_\_\_\_

Do you receive food stamps? \_\_\_\_\_ Do you receive TANF? \_\_\_\_\_

Do you receive child support payments? \_\_\_\_\_ If yes, what is the amount? \_\_\_\_\_

**X. Criminal History**

Have you ever been convicted of a felony classified as an offense against a person or family? \_\_\_\_\_

Have you been convicted of a felony classified as public indecency? \_\_\_\_\_

Have you been convicted of a felony violation of any law intended to control the possession or distribution of any substance classified as a controlled substance in the Texas Controlled Substance Act? \_\_\_\_\_

Have you been convicted of a misdemeanor classified as an offense against the person or family or as public indecency? \_\_\_\_\_

Unless proof of rehabilitation has been established, no person may be hired or kept employed in a position requiring contact with children if that person has been convicted.

Do you have an indictment against you? \_\_\_\_\_

Are there current charges pending against you? \_\_\_\_\_

The information contained in this application is correct to the best of my knowledge. I understand that the completion of application does not guarantee placement into the Together Program.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**MONTHLY INCOME AND EXPENSES**

**INCOME**

WAGES/JOB \_\_\_\_\_  
 CHILD SUPPORT \_\_\_\_\_  
 SOCIAL SECURITY \_\_\_\_\_  
 SSI \_\_\_\_\_  
 TANF \_\_\_\_\_  
 FOOD STAMPS \_\_\_\_\_  
 OTHER \_\_\_\_\_  
  
 TOTAL INCOME \_\_\_\_\_

**EXPENSES**

MEDICAL EXPENSES _____	INSURANCE _____
HOUSING	Auto payments _____
Rent _____	Life _____
Taxes _____	Health _____
Electric _____	Other _____
Gas _____	
Water _____	
Telephone _____	
Maintenance _____	
Other _____	

**DEBTS**

Source	Total Owed	Monthly Payment	Monthly Due Date	Amount Past Due

# TOGETHER PROGRAM

## Parent Needs Survey

Listed below are some needs commonly expressed by parents. Please put a check next to each item if you need help in that area.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Childcare needs.                                      | <input type="checkbox"/> Counseling needs for myself/my child.                      | <input type="checkbox"/> Anger management  |
| <input type="checkbox"/> Budgeting Skills                                      | <input type="checkbox"/> Information about nutrition, feeding, or buying food.      | <input type="checkbox"/> Time management skills.   |
| <input type="checkbox"/> Finding Medical/dental resources for myself/my child. | <input type="checkbox"/> Handling children's jealousy with their brother or sister. | <input type="checkbox"/> Career counseling   |
| <input type="checkbox"/> Parenting skills.                                     | <input type="checkbox"/> Dealing with problems with relatives.                      | <input type="checkbox"/> Help with addictions: (Circle all that apply)<br>alcohol<br>drugs<br>smoking<br>pornography |
| <input type="checkbox"/> Information about community resources.                | <input type="checkbox"/> Bible Studies  | <input type="checkbox"/> Organizational skills.  |
| <input type="checkbox"/> Discipline Techniques.                                | <input type="checkbox"/> Help with education or GED.                                | <input type="checkbox"/> House keeping skills.   |
| <input type="checkbox"/> Job skills.   | <input type="checkbox"/> Being more assertive.                                      | <input type="checkbox"/> Any other needs (list)  |
| <input type="checkbox"/> Resume writing.                                       |   |  |
| <input type="checkbox"/> Increasing my self-esteem.                            |   |  |
| <input type="checkbox"/> My relationship with others.                          |   |  |

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NAME

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DATE

(Revised 7/8/09 KLB)