PHOENIX PROGRAM
Application for Admission

Note: After completing your application please mail to**: Transitions for Life Foundation**
Att: Phoenix Re-Entry Program, 800 Westport Road Kansas City, MO 64111.

Personal Information:

Last, First_____

Alias/Nick Names_____ Phone number: _____

Hometown City _____County_____ State _____ Zip___

Date of Birth_____ Driver's License Number_____

Number of Children? _____

Names and ages

_____
_____
_____
_____

Child Support Owed _____ To Whom_____

Legal Information:

Inmate Number_____

Will you be on probation or parole? _____ For how long?_____

Name of probation/parole officer_____Phone #_____

How often will you be required to report? _____

Do you physically report, or email in report? _____

Do you have to register for any of the following: ○Violent ○Drug ○Sexual

Purpose:

What are your goals for this program? (Attach a separate paper if needed)

_____
_____
_____
_____
_____

Church/Religion/Spirituality:
(If this does not apply to you, indicate N/A)

Religious/Spiritual Affiliation: _____
Current Denomination: _____

Work History:

Employer: _____ Supervisor: _____

○Full-Time ○Part-Time ○Self-Employed ○Temporary ○Seasonal ○Contract

Dates of Employment: from _____/____/____ to____/____/____

Reason for Leaving: _____

Employer: _____ Supervisor: _____

○Full-Time ○Part-Time ○Self-Employed ○Temporary ○Seasonal ○Contract

Dates of Employment: from _____/____/____ to____/____/____

Reason for Leaving: _____

Employer: _____ Supervisor: _____

○Full-Time ○Part-Time ○Self-Employed ○Temporary ○Seasonal ○Contract

Dates of Employment: from _____/____/____ to____/____/____

Reason for Leaving: _____

Medical Information:

Are you currently under a doctor's care? ____If yes, for what?

_____
_____
_____
_____

Physician Name: _____ Physician Phone #: _____

Medications: Life sustaining medications only. Heart and Blood Pressure Medications. Psychotropic medications are NOT life sustaining medications. Our program does not allow any psychotropic medications in the program without prior approval. Any person requesting entry into the program and currently taking psychotropic medication ***will undergoe separate review. All cases are reviewed on a case by case basis.***

Please list all life sustaining medications:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

If you need to list additional medications, please attach additional sheet

Do you have any allergies? ○Yes ○No If yes, please indicate below type of allergy:

_____
_____
_____

Do you have any physical limitations that would inhibit your ability to work?
Please Note: A doctor's written approval stating the specific physical limitation(s) is REQUIRED before admission to the program and should be submitted with this application.

○Yes ○No If so, please list

_____
_____
_____

Drug Treatment;

I understand the Phoenix Re-Entry Program is not licensed by the State of Missouri as a drug treatment program.

Signature _____Date_____

I have read the above disclosure statement. I understand and agree to abide by these terms.

Signature_____ Date_____

Printed Name_____

Site Coordinator_____ Date _____

FOR OFFICE ONLY: Date Received ___/___/___ **Date Accepted ___/___/___**

Date entered in program ___/___

Approved by _____ **Date _____**

Title_____