Assembles of God Family Services Agency
HIGHLANDS Maternity Home & Adoption Agency

APPLICATION

2325 Malvern Avenue
Hot Springs, Arkansas 71901
Phone: 501-262-1660
Fax: 501-262-0115
www.agfamilyservices.org

PERSONAL INFORMATION:

Name: ____
First Middle Last

Address: ____
Street City State Zip

E-mail :____________________ Martial Status: ☐Single ☐Married ☐Divorced ☐Separated

Phone: ( )____________________ Alt. Phone: ( ) ____________________

Age:__________ Birthdate:__________________ Social Security: ____________________

Race: ____________________ Nationality: ____________________

Physical Characteristics: Height __________ Weight ________ Eye Color______ Hair Color __________

Expected Due Date: ____________________ **Desired entry date to Highlands:**__________________

How did you learn of Highlands? ____

Please state why you desire to come to Highlands Maternity Home: ____

____

Currently, what are your plans for the baby after delivery (i.e., adoption, parenting, returning home, etc.)?____________________

____

Is there currently any court involvement? ___________ If yes, please explain .

____

FAMILY INFORMATION:

What is your current living situation: ☐Residing with Parents ☐Living Independently ☐Other: Explain____________________

Parent(s)/Guardian(s): ____

Address (if different from above): ____
Street City State Zip

Home Phone: ( )____________________ Daytime Number: ( ) ____________________

Do you have any children (that you either have custody of or not)? o Yes o No

Names of Children:

Name: ____________________ Age: __________ Guardian: __________________ DOB: ________
Name: ____________________ Age: __________ Guardian: __________________ DOB: ________
Name: ____________________ Age: __________ Guardian: __________________ DOB: ________

What is your relationship with your family? ____

Is your family aware of your pregnancy? ☐Yes ☐ No Are they supportive of your plans? ☐Yes ☐No Please explain: ____

____

Have you ever lived with any person other than your biological parents/step-parents? ☐Yes ☐No

If yes, on a separate sheet of paper, please state with whom you lived, for how long, and the reasons why you lived there.

SPIRITUAL INFORMATION:

Do you currently attend church? ☐Yes ☐No Your faith/denomination:________________________________

Name of church you attend:____

Do you consider yourself to be a Christian? ☐Yes ☐No To you, what does it mean to be a Christian? ______________________

____

EDUCATION INFORMATION:

Completed High School/GED? ☐Yes ☐No Current Educational Level:______________________________

Name of School:______________________________ Phone Number: ( )______________________________

Address:____

Name of Guidance Counselor: ____

Have you ever been expelled or suspended from school? ☐Yes ☐No If yes, please explain: ____________________________

Special achievements accomplished in School:____

If resident has not received her diploma or GED, the resident must participate in the following options for her education. Please check the option the resident would like to do. *Note: These services are only offered during September through May. If you have questions please discuss with the caseworker.*

_____ Attendance at Lakeside High School or Middle School
_____ Independent Study Courses through current school if available
_____ GED

MEDICAL INFORMATION: ***Please send before arrival ALL previous medical records prior to arrival.***

Are you currently receiving prenatal care? ☐Yes ☐No Physician's Name: ______________________________

Phone: ( ) ______________________________ Last appointment: ______________________________

Address: ____

Please list any medical problems: ____

Please list all medications you are currently taking:_______________________________________

Are you allergic to any medication? ☐Yes ☐No If yes, please explain:_________________________________

Date of last: Physical Exam:____________ Dental Exam:________________ Eye Exam:________________

******Please have regular dental and eye exams taken care of before coming to Highlands. Highlands does not schedule regular check-ups.*

Have you been on any medication in the last 6 months? ☐Yes ☐No If yes, explain:____________________________

Have you used "street drugs" in the last 6 months? ☐Yes ☐No If yes, explain:_______________________________

Have you used alcoholic beverages in the last 6 months? ☐Yes ☐No If yes, explain:___________________________

Have you used cigarettes in the last 6 months? ☐Yes ☐No If yes, explain:__________________________________

Have you ever been placed in any residential treatment facilities? ☐Yes ☐No

If yes, on a separate sheet of paper, please state the name and location of the facility, the dates resided at the facility, and the reason for the placement. More information may be required before applicant may be accepted to the program.

Please check any of the following you have been diagnosed with and/or treated for: ☐ ADD/ADHD ☐ Anger Management

☐ Bi-Polar Disorder ☐ Borderline Personality Disorder ☐ Depression ☐ Dissociative Disorder ☐ Drug Dependency ☐ Eating Disorder

☐ Schizophrenia ☐ Sexual Abuse ☐ Self- Mutilation ☐ Suicide Attempt ☐Other: ____________________________

INSURANCE INFORMATION: ***If you are insured or covered under a family policy, please complete the following:***

Insurance Company:________________________________ Policy Number: ________________________________

Address: ________________________________ Phone: (   )________________________________

Name of person on policy: ________________________________ Policy Holder's SS Number: ________________________________

If you do not have insurance, you may be eligible for Arkansas Medicaid. Please bring the following:

1. *Social Security Card*
2. *Copy of your birth certificate*
3. *Picture ID (any type--school, driver's license, state ID, etc.)*
4. *Applicable, current statements from checking and savings accounts.*

BIRTH FATHER INFORMATION: ***Please complete the following about the father of the baby.***

Name: ____
First Middle Last

Address: ____
Street City State Zip

Phone: (   ) ________________________ Age: ______________ Birthdate:________________

Social Security:________________________ Race: ______________ Nationality:________________

How long have you known one another and how did you meet? ________________________________
____

Is the father of the baby aware of the pregnancy? ☐Yes ☐No

Describe your relationship with him now:________________________________
____

Is he supportive of your plans for the child? ☐Yes ☐No ☐Unknown If no, what would he like for you to do?________________
____

What involvement do you anticipate the birth father having with you during the pregnancy?________________________________
____

Highlands' Services	**Highlands' Expectations**
1. Housing, food, and supervision. 2. Spiritual guidance and education. 3. Adoption and parenting education. 4. Prenatal care and childbirth class. 5. Adoption services, as needed. 6. Life preparation instruction. 7. Continued high school education. 8. Daily living activities/chores. 9. Recreational opportunities. 10. Personal care items and maternity clothing	Highlands offers many opportunities to residents; in return, Highlands expects complete cooperation from residents in counseling, classes and activities, chores, and in following the schedule. When coming to Highlands residents who choose a parenting plan understand they must have a place to transition to after being released from the hospital. Residents who choose an adoption plan will be provided the necessary services to complete the adoption process. Residents agree to attend church and participate in group devotions. Residents also agree to use the physician and hospital chosen by Highlands for their prenatal care and delivery.

I accept Highlands services and agree to meet Highlands' expectations.

____
Applicant's Signature Date

By signing below, I verify that all information provided in the application is correct.

____
Applicant's Signature, Date

***Please enclose a recent photo of yourself, a copy of your birth certificate, a copy of your social security card, a copy of your ID, and all previous medical records pertaining to your current pregnancy.**

*** Highlands is committed to the privacy of all applicants and residents. Information provided will not be given to any source outside of Highlands without the consent of applicant or resident. All information is kept confidential. ***

ASSEMBLIES OF GOD FAMILY SERVICES AGENCY
Hillcrest Children's Home / Highlands Child Placement Services
2325 Malvern Ave. / Hot Springs, AR 71901
Ph. 501.262.1660 / fax 501.262.9345

Jay Mooney
Administrator

CONSENT FOR RELEASE OF INFORMATION

TO: ____
Person or Agency

____
Address

____
City State Zip

This Section pertains to Release of Medical Information including treatment for drug and alcohol and for psychiatric conditions.

____
Date of Birth

____
Dates of Care

This is your authority to release the requested ____
(Specify type of information)

Information regarding ____
First Middle Last

______________ ________________ to Hillcrest Children's Home / Highlands Child Placement Services/Highlands Ministries or
Social Security #

Authorized Representative listed below for the purpose of admission, treatment, or counseling while in our care.

______________________________ ______________________________
Date **Signature of Resident**

______________________________ ______________________________
Name of Authorized Representative **Signature of Parent/Guardian (if under 18)**

______________________________ **Title**

____
Signature of Authorized Representative