



CLIENT APPLICATION

Makana O Ke Akua, Inc.
"Gift of God"
CLEAN AND SOBER LIVING

APPLICANT INFORMATION

Today's Date: _____ A/O Number: _____

First Name: _____ Middle Name: _____ Last Name: _____

Suffix: _____ Preferred Name: _____ Date of Birth: _____
(if different than above)

Do you have an ancestor that is Native Hawaiian? Yes No

Race: (please select all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Marshallese |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Korean | <input type="checkbox"/> Micronesian |
| <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Japanese | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> African American | <input type="checkbox"/> Filipino | <input type="checkbox"/> Tongan |
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> Laotian | <input type="checkbox"/> Maori |
| <input type="checkbox"/> Portuguese | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Guamanian/Chamorro |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Other Asian (please include): _____ | <input type="checkbox"/> Other Pacific Islander (please include): _____ |

FINANCIAL STATUS

Are you able to meet the financial obligations of MOKA? Yes No

Do you require financial assistance through the State Contract? Yes No

CRIMINAL BACKGROUND

Convicted of a violent crime? Yes No Sex Offense: Yes No [Minor Adult]

Length of incarceration: _____ Number of times incarcerated: _____

Are you an active gang member? Yes No Have you ever been in a gang? Yes No

MEDICAL INFORMATION

Mental Health Diagnosis? Yes No If yes, what?

Are you on any type of medication(s) for this condition? Yes No

Do you have any physical restrictions? Yes No If yes, what? _____

Have you ever tested positive for HIV or Hepatitis C? Yes No

CHEMICAL DEPENDENCY

Drug of Choice: Amphetamines Methamphetamines Marijuana Opiates Benzos Alcohol
(check all that applies) Other _____

List your high risk areas: _____

SUPPORT/FAMILY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____