

Hancock County ADAMHS Board Recovery Residence Application Form

***Please read disclosure statement at end of form before completion*

Application Date: _____

How did you hear about this Recovery Residence?

Applicant Information

Name: _____

M/F: _____ **DOB:** _____ **Age:** _____ **SSN:** _____

Current Address: _____

Phone Number: _____

Name of Emergency Contact: _____

Relationship: _____

Phone #: _____

Are you presently homeless or at-risk of homelessness?

YES _____ **NO** _____

If YES, reason for homelessness:

- () Eviction () Overcrowded () Other _____
- () Affordability () Behind in Rent () Shelter () Domestic Violence

Are you currently: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Exiting Incarceration
<input type="checkbox"/> Receiving Medication Assisted Treatment Services
<input type="checkbox"/> Other (please describe): _____ | <input type="checkbox"/> Leaving a Residential Treatment Program
<input type="checkbox"/> Being Discharged from a Hospital |
|--|---|

Describe Current Living Situation:

Explain Reasons For Seeking a Recovery Residence Living Environment:

Check the categories that best describe your Race and Ethnicity:

- African American
 Asian/Pacific Islander
 American Indian/Alaskan Native
 White
 Hispanic
 Non-Hispanic
 Other (please describe): _____

Marital Status:
 Single
 Married
 Partner Family
 Divorced/Widowed
 Separated

Children

	Name	M/F	Age
1.	_____		
2.	_____		
3.	_____		

Do you have visitation with your children? YES _____ NO _____

Are you working toward reunification with your children? YES _____ NO _____

If YES, explain visitation schedule and any requirements for supervised visitation: _____

Please Check ALL Categories That Apply To You:

	Yes	No
Are you a veteran?	<input type="checkbox"/>	<input type="checkbox"/>
Do you own a car?	<input type="checkbox"/>	<input type="checkbox"/>

Mark All Benefits Received or Applied For:

- Food Stamps
 Medicaid
 Medicare
 Health Insurance
 Housing Voucher
 VA Medical Benefits
 Other (please specify): _____

Describe amount and type of benefit: _____

Do you have someone who manages your finances? YES _____ NO _____
 If YES, Who? Name: _____

Legal Guardianship

Do you have a legal guardian? YES _____ NO _____

If YES: Name of Guardian/Relationship: _____
 Address: _____
 Phone: _____

Monthly Income

Source	Amount
Alimony	_____
Child Support	_____
Employment	_____
Retirement/Pension	_____
School Loan	_____
SSI/SSDI	_____
Welfare/ADC/TANF	_____
Veteran's Administration	_____
Any Other Income	_____
Total Income	_____

Applicant's Employment Status: (Mark All That Apply)

	For How Long?
Permanent full time <input type="checkbox"/>	_____
Permanent part time <input type="checkbox"/>	_____
Temporary full time <input type="checkbox"/>	_____
Temporary part time <input type="checkbox"/>	_____
Enrolled in college <input type="checkbox"/>	_____
Enrolled in training program <input type="checkbox"/>	_____
Not employed <input type="checkbox"/>	_____

Current Employer: _____ Phone: _____
 Job Title: _____

Legal Issues (Legal Issues Do Not Necessarily Prohibit Residence; Public Record Will Be Checked)

Do you have legal charges pending or a conviction? YES _____ NO _____

If YES, what is the charge? _____

Which Court is hearing the case? _____

List Type and Location of all Juvenile Offenses:

List Type and Location of all Adult Offenses:

Are you currently on probation? YES _____ NO _____

If YES, what charge? _____
 What State and County? _____

Name of Probation/Parole Officer _____
 Contact Phone # _____

Are you a Registered Sex Offender?	YES _____	NO _____
Victim of Domestic Violence?	YES _____	NO _____
CPO or Restraining Order?	YES _____	NO _____
History of violence toward self, others or property?	YES _____	NO _____
Suicide thoughts or attempts?	YES _____	NO _____
Acts of Arson?	YES _____	NO _____

If you answered YES to any of the above questions, please explain:

Medical Information

Are you experiencing any medical problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dietary restrictions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you use tobacco products?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diagnosed with a seizure disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sleeping problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dental problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please describe any items marked YES:

Please check those issues that apply to you:

- Mental Health Issues**
- Substance Abuse (Alcohol, Drugs)**
- Behavioral Issues**
- Physical Disability**
- Learning Disability**

Describe Your Current Psychological or Alcohol/Drug Condition. (What is your Diagnosis?):

Current Treatment Providers

Name	Agency	Phone #

Medications (List all current medications prescribed, non-prescribed and over the counter):

Medication Name	Prescribing Physician

List all **Mental Health Hospitalizations** in the past 3 years:

Month/Year	Hospital	Reason

List all **Hospitalizations for Addiction-Related Issues** in the past 3 years:

Month/Year	Hospital	Reason

List Any Other Community Agencies You Have Been Involved With:

Name of Agency/Organization/Self Help Groups	Reason

Recovery Support Goals/Needs:

What Are Your Substance(s) of Choice? _____

How Long Have You Been Clean and Sober From Using Alcohol and/or Other Drugs? _____

Describe Your Current Recovery Goals: _____

What Do You Expect to Gain From Living At A Recovery Residence? _____

Describe What You Have Done For Your Recovery That Has Been Successful: _____

Describe What You Have Done For Your Recovery That Has NOT Been Successful: _____

Do You Have Individuals In Your Life Open to Helping You Establish Recovery? If So, Who?

Are There People In Your Life Who Might Be Unsupportive of Your Recovery Journey? If So, Who?

What Are The Best Ways We Could Support You To Help You Establish Long-Term Recovery?

Please Provide 3 References (Friends, Family, Sponsors, Clinicians, Etc.):

Name	How do you know this person?	Phone #

****I verify that all information provided as part of this application is truthful and accurate. I also understand that failure to disclose correct information could lead to my disqualification for residency.**

Signature of Applicant

Date

Authorization (Disclosure of Information Will Be Held in Strict Confidence)

I authorize the Hancock County ADAMHS Board to conduct a thorough personal investigation including, but not limited to:

- Credit Reports
- Employment/Income Verification
- Reference Checks
- Current and Previous Landlords
- Law Enforcement Authorities
- Criminal Background Checks
- School Records
- Drug Screen Check

I understand that any cost associated with these investigations will be at the expense of the Hancock County ADAMHS Board.

I hereby release these third parties from all liability for any damage whatsoever for providing information to the Hancock County ADAMHS Board in connection with this application. I also release the Hancock County ADAMHS Board, its agents, employees and representatives from any liability in connection with their collection and use of information obtained from third parties during this application process.

I also understand that if I do not provide authorization to this investigation, or refuse to complete the criminal background check, or drug screen test, the Hancock County ADAMHS Board may not provide approval for residency. I agree to hold the Hancock County ADAMHS Board harmless for such refusal.

Applicant's Signature

Date

