Focus: Recovery Residence Application Form

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

Application Date: _____

What home are you applying for?

Men's Home ☐ **Women's Home** ☐ **Mom's Home** ☐

For Mom's Home: Due Date? _____

Are you a part of the MOM's Program at BVH? Yes ☐ **No** ☐

How did you hear about this Recovery Residence?

_____

Applicant Information

Name: _____

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

Current Address: _____

Phone Number: _____

Email Address: _____

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)

☐ **Exiting Incarceration** ☐ **Leaving a Residential Treatment Program**

☐ **Receiving Medication Assisted Treatment Services** ☐ **Being Discharged from a Hospital**

☐ **Other (please describe):** _____

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?	☐	☐
Do you own a car?	☐	☐

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	☐	_____
Permanent part time	☐	_____
Temporary full time	☐	_____
Temporary part time	☐	_____
Enrolled in college	☐	_____
Enrolled in training program	☐	_____
Not employed	☐	_____

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** ☐	**No** ☐
Allergies?	**Yes** ☐	**No** ☐
Dietary restrictions?	**Yes** ☐	**No** ☐
Do you use tobacco products?	**Yes** ☐	**No** ☐

Diagnosed with a seizure disorder? **Yes** ☐ **No** ☐

Sleeping problems? **Yes** ☐ **No** ☐

Dental problems? **Yes** ☐ **No** ☐

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 #
1.		
2.		
3.		

****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