



567-250-8700 (Fax)

419-423-5071(Office)

To: \_\_\_\_\_

# of Pages \_\_\_\_\_

From: \_\_\_\_\_

Fax #: \_\_\_\_\_

Date: \_\_\_\_\_

**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?	<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	_____
<b>Total Income</b>	_____

**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       No   
 Sleeping problems?      Yes       No   
 Dental problems?      Yes       No

Please describe any items marked YES:

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**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?):**

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**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?**

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**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





