**APPLICATION FOR PROGRAM PARTICIPATION**

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| Date |
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| **Name** | **Address** | **City** | **County** | **State** | **Zip** |
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| **Phone Number** | **Previous Address if less than 1yr.** |  | **Email** |
|  |  |  | |

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| **Social Security #** | **Drivers License/State I.D.** | **Date of Birth** | **Age** | **# of Dependents** |
| **\* \*** |  | / / |  |  |

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| How Did You Hear of about this program? |
| Case Manager Treatment Agency Friend/Family Court Walk-In **€** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| If you were referred by an Agency/Organization, complete the following information: |
| **Agency/Organization Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_  **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ x\_\_\_\_\_\_\_\_\_ **Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Worker/Representative Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Case #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please Answer The Following Questions YES or NO:**

Are you currently homeless?  **YES NO**

If YES, are you living in a: Shelter/Halfway House Friends/Family Home Transitional Housing/Motel **N/A**

Are you living somewhere not habitable such as a car or condemned building?  **YES NO**

Are you currently being evicted, or do you have a court ordered eviction against you?  **YES NO**

Have you ever been convicted of a felony?  **YES NO**

If YES, **County & State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Charge/s:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, you may provide an explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any pending charges?  **YES NO**

If YES, **County, & State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_ **Charge/s:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, you may provide an explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any outstanding warrants?  **YES NO**

If YES, **County, & State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Charge/s:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, you may provide an explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently on Probation or Parole?  **YES NO**

If yes, who is your probation or parole officer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you involved in a specialty court?:  Drug Court Family Dependency Court Sobriety Court

If you are involved in one of these specialty courts, who is your Case Manager? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you being Physically, Mentally or Sexually Abused?  **YES NO**

If YES, by whom **(optional)**: Partner/Spouse Parent/Guardian Family Member Teacher/Neighbor Other

Are you currently pregnant? **YES NO**

If yes, what is your due date? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have dependent children? **YES NO**

If yes, do you have custody of your children?  **YES NO**

If no, do you have an open child protective services case trying to regain custody of your children?  **YES NO**

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| If you have a child or children living with you, complete the following information: |
| **1. Name (First & Last):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB \_\_\_\_\_\_\_ Boy € Girl School/grade: \_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_**  **2. Name (First & Last):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB \_\_\_\_\_\_\_ Boy € Girl School/grade: \_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_**  **3. Name (First & Last):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB \_\_\_\_\_\_\_ Boy € Girl School/grade: \_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_** |

Are you currently enrolled in a Substance Abuse Treatment Program?  **YES NO**

Have you recently completed Substance Abuse treatment?  **YES NO**

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| If you are currently enrolled in, or have completed a Treatment Program, complete the following information: |
| **Agency/Organization Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Service type: Outpatient € Detox Residential € Methadone Women’s Specialty Services**  **Starting Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**  **Therapist Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Women’s Specialty Case Manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

Have you or any of your children (if applicable) been diagnosed with any Mental Illness?  **YES NO**

If YES, who has been diagnosed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, does this person take prescribed medication for their illness?  **YES NO**

**Medication:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, does this person have violent, aggressive or disruptive tendencies?  **YES NO**

If YES, is behavior controlled with medication prescribed?  **YES NO**

Are you or your children currently receiving mental health services?  **YES NO**

If yes, where: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Who is your mental health therapist? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you or your child (if applicable) been diagnosed with a contagious disease?  **YES NO**

If YES, what is the contagious disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, does this person take prescribed medication for their contagious disease?  **YES NO**

Have you and your child or children (if applicable) been tested for T.B. within the past year? **YES NO**

OB/GYN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **List all medications you are currently taking as prescribed; include any medications your child that lives with**  **you takes:** | | | |
| **Medication** | **Circle One** | **Prescribing Doctor** | **How Often** |
|  | **Self or Child** |  |  |
|  | **Self or Child** |  |  |
|  | **Self or Child** |  |  |
|  | **Self or Child** |  |  |
|  | **Self or Child** |  |  |
|  | **Self or Child** |  |  |
|  | **Self or Child** |  |  |

**Please indicate all sources of income:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Source of Income** | **Amount Received** | **How Often** |
|  |  | **$ .00** | **week bi-weekly month** |
|  |  | **$ .00** | **week bi-weekly month** |
|  |  | **$ .00** | **week bi-weekly month** |

Would you bring a car to the program? **€ Yes No**

If yes, you must show a valid driver’s license, proof of insurance and registration.

How long have you been sober (from alcohol and/or drugs)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date of last use)

What were you using?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you attend AA or NA or other recovery related meetings? **€ Yes No**

If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a sponsor? **€ Yes No**

**How do you think transitional housing will benefit you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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I hereby declare that the information submitted in this program application is true to the best of my knowledge. I understand that completing this application does not guarantee acceptance into transitional housing. I further understand that applicants must meet all qualifications required by SWMBH as the program manager. I also understand this is a recovery program and not a landlord/tenant arrangement.

I understand that providing false information or the omittance of information deemed important to the program can lead to discharge from the transitional housing.

Please be advised by signing this document, you authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (house name) and its representatives to obtain and share information regarding your application for program participation. Any and all information submitted in this application will be held confidential and will not be released to any third party without prior authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorized Representative Date

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| **For Office Use Only** |  |  |  |  |
| **Approved € Yes No** | **if no, referral:** | **Special needs or accommodations:** | **Interview Date:**  **\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_** | |
| **Start Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** | **ID presented: Drivers License**  **State ID** |  |  | |

### References

**Personal:**

Name:

Address

Phone: Email:

Length Known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:

Address

Phone: Email:

Length Known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:

Address

Phone: Email:

Length Known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### References

**Professional:**

Name:

Address:

Phone: Email: Fax:

Length Worked With:

Comments:

Name:

Address:

Phone: Email: Fax:

Length Worked With:

Comments:

Name:

Address:

Phone: Email: Fax:

Length Worked With:

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