



Community of Hope, Inc.
Supportive Recovery Housing Services
ADMISSION APPLICATION

Name: _____ House Phone: _____ Your Cell: _____
Your Workers name: _____ Workers Phone: _____ Ext: _____
Your Case Manager Name: _____ Agency: _____ Phone: _____
Projected Release Date: _____ Is this a definite date: _____ yes or no
Pick up time: _____ Facility or Home Address: _____

Main Goal:

1. Identity
2. Inner Healing
3. Employment
4. Future Housing
5. Reconciliation

2 Zero Tolerance Rules:

SOBRIETY
PEACE

For your safety and the safety of all the other women there are 2 things we will promise you. Using any substance, legal or not is not allowed on premises or while in residence. When we test and discover "use", or someone does not submit to a test, they will be asked to leave. Peace is truly an integral aspect of recovery and anyone not promoting peace or who disturbs the peaceful atmosphere of the home may not stay.

To be eligible:

A woman (18 or older) needs to provide proof that she has been sober from all forms of substance abuse and has the desire to live a sober, productive life style. WE require that you leave your old life behind including dating and sex. This may be a foreign concept now but you are with us for just a short time .. you need to work on you!! No Relationships allowed! You may be asked to leave if you cannot choose to work on you. Please PRAY on this decision. Coming into our home **will change you**. You need to be ready, ask God "is this the place for me? Am I ready to go to a place like this?" Don't waste the opportunity - it may only come once!!

House requirements:

- Ability to find/retain employment and do volunteer work
- If unable to be employed: Proof from a physician needs to be provided & the resident will be expected to pay rent and still do all the activities required of the other residents.
- Help with Community service projects such as Yard Sales and Serving others in a food pantry or clothing pantry.
- Be Part of the recovery meetings provided or assigned.
- Attend Spiritual meetings and studies.
- As an occupant you are required to pay rent and house fees on a timely basis. If you are receiving benefits from a benefactor you are required to get your paperwork done (you are responsible for your rent).
- A house member must be able to maintain sobriety from drugs and /or alcohol while proactively working on personal goals, such as spiritual growth, improving or increasing skills or income potential and seeking permanent housing.
- Submit to regular drug screening.

Call Annette 860-912-8983
or email getannette@aol.com
All completed forms can be
e-FAX TO 1-860-464-0773 ATT: JULIE B.
Then call for an interview 860-912-8983



PERSONAL INFORMATION: (Must print legibly)

Today's date: _____

CURRENT LIVING SITUATION:

Name (first/ middle initial/last) _____

Birth date _____ Social Security # _____

Insurance# _____ HuskyD _____ yes or no

Cash Assistance _____ yes or no

Are you in Clinical Treatment _____ yes or no List: Doctor, Psychiatrist and or therapist

Current Home Address _____

How long have you been in your current living situation? (Please check one)

1 week or less

More than 3 months, but less than 1 year

More than 1 week, but less than 1 month

1 year or longer

1 to 3 months

Street, city, state & zip of last permanent address: _____

FAMILY INFORMATION:

1. Marital Status Single Married Separated Divorced

2. Do you Live with your parents? _____

3. Do you have siblings (how many? Ages and genders) _____

4. Married Spouse's name (if applicable) _____

5. Do you have children? (ages of all) _____

6. Current living arrangements of your children _____

7. Do your plans include family reunification? _____

Is your family supportive of your recovery? _____

Are your family and friends a positive or negative influence? ___ Positive ___ Negative

SUBSTANCE ABUSE HISTORY AND MEDICAL INFORMATION:

Alcohol Date of last use: _____ Cocaine Date of last use: _____

Crack Date of last use: _____ Hallucinogens Date of last use: _____

Inhalants Date of last use: _____ Rx Drugs Date of last use: _____

Opiates Date of last use: _____ Sedatives Date of last use: _____

Other Date of last use: _____ Over counter Date of last use: _____

What is your drug of choice? _____

Age of first use: _____

What was your daily drug consumption? _____



DO YOU HAVE A MENTAL HEALTH DIAGNOSIS?

YES NO

If yes, what is your diagnosis? _____

Are you on medications for this diagnosis? YES NO

DO YOU HAVE ANY CURRENT MEDICAL PROBLEMS? IF YES EXPLAIN

YES NO

If yes, what is your diagnosis? _____

Are you on medications for this diagnosis? YES NO

LIST ALL MEDICATIONS AND DOSAGES YOU ARE PRESENTLY TAKING AND WHAT THEY ARE FOR:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is your current Spiritual Life and affiliations:

CONDITIONS CONTRIBUTING TO ADDICTIVE LIFESTYLE (check the conditions that led to your substance abuse and put a 'C' next to conditions that were a consequence of your substance abuse)

- | | | |
|--|--|--|
| <input type="checkbox"/> Criminal activity | <input type="checkbox"/> Loss of income/unemployment | <input type="checkbox"/> Anxiety/fear |
| <input type="checkbox"/> Divorced/separated | <input type="checkbox"/> Loss of public assistance | <input type="checkbox"/> Spiritual depravity |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Loss of transportation | <input type="checkbox"/> Didn't know where to get help |
| <input type="checkbox"/> Relationship issues | <input type="checkbox"/> Homelessness | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Family abuse | <input type="checkbox"/> Mental health/ illness | <input type="checkbox"/> Not ready to stop using |
| <input type="checkbox"/> History of abuse | <input type="checkbox"/> Physical illness | <input type="checkbox"/> Associated stigma |
| <input type="checkbox"/> Generational drug/alcohol use | <input type="checkbox"/> Stress | <input type="checkbox"/> Insurance coverage issues |
| <input type="checkbox"/> Loss of a loved one | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Cost of treatment |
| <input type="checkbox"/> Prescribed Narcotics | <input type="checkbox"/> Gambling | |



Please list history of mental and substance abuse treatment starting with current or most recent:

ARE YOU CURRENTLY IN TREATMENT? YES NO

Name of **current** Facility _____ City, St _____

Date admitted _____ Date of completion _____

Case Manager's Name & Phone # _____

Counselor's Name and Phone # _____

When is your projected commencement Date? _____

What are your housing options besides COH House? _____

Did you successfully complete the program? If not explain why _____

Where did you go when you left there? _____

How long did you maintain sobriety? _____ What went wrong? _____

LEGAL MATTERS:

Do you have any outstanding warrants or current charges pending? _____

Have you ever been arrested? _____ What were the charges and convictions? _____

Arrest Date _____ Sentence (years & months) _____

Parole or Probation time _____ Parole or Probation Officer's name and Phone # _____

Parole or probation conditions (counseling/treatment) _____

Date you will be off parole or probation _____

HISTORY OF ARRESTS AND CONVICTIONS?



Have you had any disciplinary reports during your incarceration? ____ Yes ____ No
 If so, what were the reports for and the outcome/consequence? _____

EDUCATION AND JOB INTERESTS:

Please circle the last grade you completed in school 9 10 11 12 College 1 2 3 4
 Other (i.e. trade school, etc) _____

List significant jobs you have held _____

What would you like to do in the future? _____

INCOME

Please list all sources of income:	Per week/ Per month	Per week/Per month
<input type="checkbox"/> A veteran's disability payment	/	<input type="checkbox"/> Private disability insurance /
<input type="checkbox"/> Alimony	/	<input type="checkbox"/> Railroad retirement /
<input type="checkbox"/> Other spousal support	/	<input type="checkbox"/> Rental income /
<input type="checkbox"/> Annuities	/	<input type="checkbox"/> Retirement disability /
<input type="checkbox"/> Child support	/	<input type="checkbox"/> Retirement income from Social Security /
<input type="checkbox"/> Contributions from other people	/	<input type="checkbox"/> SAGA /
<input type="checkbox"/> Dividends (investments)	/	<input type="checkbox"/> Section 8, public housing or rental assistance /
<input type="checkbox"/> Earned/Employee income	/	<input type="checkbox"/> Self employment wages /
<input type="checkbox"/> Food stamps	/	<input type="checkbox"/> Special supplemental nutrition program /
<input type="checkbox"/> General assistance	/	<input type="checkbox"/> SSDI /
<input type="checkbox"/> HUSKY/S-CHIP	/	<input type="checkbox"/> SSI /
<input type="checkbox"/> Savings / Interest (Bank)	/	<input type="checkbox"/> State disability /
<input type="checkbox"/> Medicaid	/	<input type="checkbox"/> TANF /
<input type="checkbox"/> Medicare	/	<input type="checkbox"/> TANF child care services /
<input type="checkbox"/> No financial resources	/	<input type="checkbox"/> TANF transportation services /
<input type="checkbox"/> Other	/	<input type="checkbox"/> Unemployment insurance/compensation /
<input type="checkbox"/> Other TANF-Funded Services	/	<input type="checkbox"/> Veteran's administration medical services /
<input type="checkbox"/> Pension from a former job	/	<input type="checkbox"/> Veteran's pension /
<input type="checkbox"/> Pension/retirement	/	<input type="checkbox"/> Worker's compensation /



***Are you currently working part-time?** YES NO

If yes, name of employer, city and state _____

***Are you currently working full-time?** YES NO

If yes, name of employer, city and state _____

Please list your past two jobs:

Name of the employer _____ Dates of employment _____

Name of the employer _____ Dates of employment _____

Affirmation

I am here by applying to COH, Inc. and release this information for use in making a decision about my acceptance. I certify that the information contained in this application is true and complete. I further understand that any false statements or misrepresentations made by me on this application or any supplements thereto will be sufficient ground for rejection of this application or expulsion from COH, Inc. I have read the house rules and agree to willingly abide by the policies of COH, Inc. I further understand that this is a Christ-centered ministry with Christian values and expectations for my behavior.

Signature: _____ **Date:** _____

Community of Hope, Inc.
1649 Rt 12, Ste 2
Gales Ferry, CT 06335
860-912-8983



Please share any other information you think may be of importance for us to understand your needs and goals.

STRENGTHS:

WEAKNESSES:

Triggers:

DIFFICULTIES:

What has gotten you here? use the back if you need to.

GOALS:

What are your plans while you are with us?

What do you plan to do after you leave us?

What are your dreams?