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

Community of Hope, Inc.

Supportive Recovery Housing Services
ADMISSION APPLICATION

NEEDS TO BE COMPLETED BY APPLICANT WITHOUT ASSISTANCE

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 monthly fees 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.
- As an occupant you are required to pay a monthly bed fee 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 fees).
- 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 Faith 860-912-8983
or email faykayday@hotmail.com
All completed forms can be
e-FAX TO 1-860-464-0773 ATT: JULIE B.
Then call for an interview 860-912-8983

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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 1 week, but less than 1 month
- ☐ 1 to 3 months
- ☐ More than 3 months, but less than 1 year
- ☐ 1 year or longer

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:** ____________

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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)

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

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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?
____
____

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

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***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:**__________

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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?