SOBER HOUSING APPLICATION FORM

Thank you for your interest in His House for Her, a Christian, Sober Housing Program that helps women heal and become self-sufficient.

Please return the completed application to the Program Director by email to amber@hishouseforher.org or by regular mail to His House for Her, PO Box 830455, Ocala FL, 34483.

PLEASE NOTE

- Completing this application does not guarantee acceptance into sober housing.
- Considered applicants will be interviewed.
- Information provided in this application will be verified for accuracy and truth.

BRIEF OVERVIEW

- We are a Christian sober housing program for women.
- We partner with community organizations to best meet your needs.

SOBER HOUSING GUIDELINES AND EXPECTATIONS

- We are a DRUG AND ALCOHOL-FREE program & a SMOKE AND VAPE-FREE facility.
- Random substance tests and property searches will be conducted.
- Upon intake you will undergo a substance screening and in the event of a positive result, you are required to enter a detox program.
- Residents are to secure a job within 14 days of the initial move-in date.
- The cost of housing is $135 per week (which includes substance tests).
- Residents will participate in mandatory programming (church, Care Team meetings, recovery meetings, outreach classes, and individual therapy sessions).
- Be aware the following is grounds for immediate dismissal from the Sober Housing:
  - Refusal to submit to a substance test or a positive test result.
  - Possession of illegal substances, drug paraphernalia \ and/or possession of weapons.
  - Stealing and violence of any kind (towards self and/or others).

PERSONAL INFORMATION

DATE OF APPLICATION	
NAME	
PHONE #	
E-MAIL ADDRESS	
ADDRESS	
DOB & AGE	
SOCIAL SECURITY #	
HOW DID YOU HEAR ABOUT US	
DO YOU POSESS A VALID DRIVER'S LICENSE	☐ Y ☐ N- If no, explain:
DO YOU POSESS VALID STATE ID	☐ Y ☐ N- If yes, what State:

EMERGENCY CONTACTS

NAME	PHONE	ADDRESS	RELATIONSHIP

RELATIONSHIP STATUS

CURRENT LEGAL MARITAL STATUS	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
PARTNER'S NAME	
DESCRIBE RELATIONSHIP WITH PARTNER	

PREVIOUS INCARCERATION

OF TIMES YOU HAVE BEEN INCARCERATED:

_____

MOST RECENT INCARCERATION INFORMATION

DATE	CHARGE	INSTITUTION (JAIL/PRISON)	DURATION TIME SERVED

CRIMINAL HISTORY

HAVE YOU EVER BEEN CONVICTED OF VIOLENT CHARGES	☐ Yes ☐ No
HAVE YOU EVER BEEN CONVICTED OF CHILD ABUSE	☐ Yes ☐ No
HAVE YOU EVER BEEN CONVICTED OF SEXUAL CHARGES	☐ Yes ☐ No
HAVE YOU BEEN CONVICTED OF ASSAULT	☐ Yes ☐ No
HAVE YOU BEEN CONVICTED OF ARMED ROBBERY	☐ Yes ☐ No

IDENTIFY OTHER CHARGES NOT LISTED IN ABOVE TABLE

CURRENT INCARCERATION

DOC #	
NAME OF CORRECTIONAL INSTITUTE	
ADDRESS OF CORRECTIONAL INSTITUTE	
DATE OF INCARCERATION	
RELEASE/END OF SENTENCE DATE	
CONTACT INFO FOR INSTITUTION CASE WORKER	

LEGAL INFORMATION / PROBATION INFORMATION

DO YOU HAVE UPCOMING COURT DATES	☐ Yes ☐ No If yes, when & why:
DO YOU HAVE OUTSTANDING WARRANTS	☐ Yes ☐ No If yes, explain:
DO YOU HAVE OPEN LEGAL CASES/CHARGES	☐ Yes ☐ No If yes, explain:
ARE YOU CURRENTLY ON PROBATION	☐ Yes ☐ No If yes, name and contact info. of probation officer: Name and contact info. of attorney:

I hereby authorize and consent for the above ATTORNEY to provide information about my pending legal charges including court dates, expectation of release at sentencing, release dates, or any other pertinent legal information to His House for Her, Inc.

_____ _____

Applicant Printed Name Applicant Signature

_____

Date

EMPLOYMENT

LIST YOUR TRADE/PROFESSION:

_____

MOST RECENT WORK HISTORY

FROM (MONTH/YEAR)	TO (MONTH/YEAR)	EMPLOYER NAME	POSITION WITHIN ORGANIZATION	REASON FOR LEAVING

MEDICAL INFORMATION AND HISTORY

☐ I consent to provide this information.

_____ _____

Applicant Printed Name Applicant Signature

_____

Date

LIST OF CURRENT PRESCRIBED MEDICATIONS

NAME OF MEDICATION	REASON FOR MEDICATION	DOSAGE	ARE YOU CURRENTLY TAKING THE MEDICATION
			☐ Yes ☐ No- If no, explain:
			☐ Yes ☐ No- If no, explain:
			☐ Yes ☐ No- If no, explain:

NAME OF MEDICATION	REASON FOR MEDICATION	DOSAGE	ARE YOU CURRENTLY TAKING THE MEDICATION
			☐ Yes ☐ No- If no, explain:
			☐ Yes ☐ No- If no, explain:
			☐ Yes ☐ No- If no, explain:
			☐ Yes ☐ No- If no, explain:

LIST OF OVER-THE-COUNTER MEDICATIONS/VITAMINS/SUPPLEMENTS CURRENTLY BEING TAKEN

NAME OF PRODUCT	REASON FOR PRODUCT	DOSAGE

CURRENT MEDICAL STATUS

ARE YOU CURRENTLY ON MAT PROGRAM	☐ Yes ☐ No If yes, indicate the Medical Assisted Treatment: ☐ Subutex ☐ Suboxone ☐ Vivitrol (monthly injection) ☐ Other:
DO YOU HAVE PHYSICAL LIMITATIONS	☐ Yes ☐ No- If yes, explain:
DO YOU HAVE MEDICAL NEEDS THAT COULD PUT YOU OR OTHERS AT RISK	☐ Yes ☐ No If yes, identify which of the following: ☐ Surgeries: ☐ Dietary requirements: ☐ Allergies: ☐ STDs: ☐ Seizures: ☐ Other:
DO YOU HAVE SLEEP RELATED ISSUES	☐ Yes ☐ No If yes, identify which of the following: ☐ Insomnia, explain: ☐ Nightmares, explain: ☐ Night terrors, explain: ☐ Sleepwalking, explain: ☐ Sleep apnea, explain: ☐ Other:

MENTAL HEALTH INFORMATION AND HISTORY

☐ I consent to provide this information.

_____ _____

Applicant Printed Name Applicant Signature

_____

Date

MENTAL HEALTH STATUS

DO YOU HAVE A DIAGNOSED MENTAL ILLNESS	☐ Yes ☐ No If yes, list all diagnoses:
HAVE YOU ATTEMPTED SUICIDE	☐ Yes ☐ No- If yes, indicate: # of times: Date of most recent attempt:
HAVE YOU BEEN BAKER-ACTED	☐ Yes ☐ No- If yes, indicate: # of times: Date of most recent incident:
HAVE YOU EXPERIENCED AN EATING DISORDER	☐ Yes ☐ No If yes, indicate the following type: ☐ Anorexia Nervosa Currently active: ☐ Yes ☐ No If no, what was the date of the last episode: _____ ☐ Bulimia Nervosa Currently active: ☐ Yes ☐ No If no, what was the date of the last episode: _____ ☐ Binge Eating Disorder Currently active: ☐ Yes ☐ No If no, what was the date of the last episode: _____

	☐ Avoidant Restrictive Food Intake Disorder Currently active: ☐ Yes ☐ No If no, what was the date of the last episode: _____

SUBSTANCE ABUSE, USE AND HISTORY

LIST ALL MIND ALTERING & LIFE-CONTROLLING SUBSTANCES USED (ALCOHOL/DRUGS/OTHER)

NAME OF SUBSTANCE	AGE WHEN FIRST USED	DATE OF LAST USE

What is your drug of choice_____

What triggers could cause you to relapse?

_____

_____

LIST PREVIOUS TREATMENT PROGRAMS

NAME OF PROGRAM	DATES (WHEN TO WHEN)	
		Successfully Completed ☐ Yes ☐ No If no, reason for discharge:

NAME OF PROGRAM	DATES (WHEN TO WHEN)	
		Successfully Completed ☐ Yes ☐ No If no, reason for discharge:
		Successfully Completed ☐ Yes ☐ No If no, reason for discharge:

PERSONAL HEALING/RECOVERY GOALS

WHY ARE YOU SEEKING SOBER HOUSING?	
WHAT MOTIVATES YOU TO BE SOBER/HEAL?	
WHAT IS YOUR TOP 3 IMMEDIATE GOALS?	1. _____ 2. _____ 3. _____
WHERE DO YOU SEE YOURSELF IN 1 YEAR?	

SPIRITUAL LIFE

What is your relationship with God/Jesus/Holy Spirit?

RELEASE OF INFORMATION

As part of my application process for the Sober Housing Program at House for Her, Inc., I, _____, hereby authorize any of the entities specified below to release without liability, information regarding my physical, mental health, and psychiatric medical history, substance use history, history of treatment for substance use, employment, income, and/or criminal background.

I understand that this authorization can only be used to obtain information about me that is pertinent to my eligibility for the programs at His House for Her, Inc. Pertinent information includes my physical and mental health medical history, my substance use history, history of treatment for substance use, and my ability to pay required program fees.

The following groups or individuals will be contacted as deemed necessary. The groups or individuals that may be contacted include, but are not limited to:

- Any, and all, Physicians
- Any, and all, Treatment and Recovery Centers
- Any, and all, Treatment Providers, Clinicians and Therapists
- Past/Present Employers
- Background Check Providers
- Attorney, Probation and/or Parole Office and Department of Corrections
- Department of Children and Families, Guardian-ad-Litem Program and any case management agencies
- Friends, Personal Contacts, Family Members
- Any, and all, social service agencies pertinent to my treatment and recovery

CONDITIONS:

I, _____, agree that a photocopy of this authorization may be used for the purposes stated above. The original of this authorization is on file and will stay in effect for a year from the date signed. I understand that I have a right to review this file and correct any information that I can prove is incorrect.

ACKNOWLEDGEMENT:

My signature below signifies that I have read and understand the terms and conditions set forth in this Release of Information.

_____ _____

Applicant Printed Name Applicant Signature

_____

Date