

Hope House Participant Application

Today's Date: ___/___/___

Name: _____

Age: _____ DOB: ___/___/___ Sobriety Date: ___/___/___

House Applied For (circle one):

Men's Hope House – Wausau Women's Hope House – Antigo

Home / Last Address: _____

City, State, Zip: _____

County of Residence (circle one): Marathon Langlade Lincoln

Cell Phone Number: (____) _____ - _____

Social Security Number: _____ - _____ - _____

Do you have a recovery support person? Y N

Sponsor/Recovery Coach/ Peer Support Name:

Phone Number: (____) _____ - _____

Drug(s) of Choice: _____

Are you currently on probation / parole / house arrest? Y N

If yes, until when? _____

Name of Agent/Officer: _____

Officer's Phone Number: (____) _____ - _____

Are you currently receiving any other services? Y N

If yes, what services are you receiving?

Hope House rent is currently **\$575 per month.**

Do you currently have a source of income? Y N

Employer / Source of Income: _____

Supervisor Name: _____

Phone Number: (____) _____ - _____

If there is no income, how do you anticipate paying your rent?

Marital Status (circle one): Married Single

Children: Y N **Number of Dependents:** _____

Where do your dependent children live? _____

One requirement for Hope House is that you have recently completed inpatient treatment or are engaged in outpatient treatment. What treatment are you actively engaged in or have recently completed?

If you are currently inpatient, what is your anticipated discharge date? ___/___/___

What did you learn from your treatment?

What kind of support system do you have in place?

Do you have alternative safe housing if sober living is not an option? If so, where?

Are you currently taking any controlled medications? If yes, list below:

Please share any other information you feel is important for us to know:

Personal References

Reference #1

Name: _____
Address: _____
Phone: (____) _____ - _____ Relationship: _____

Reference #2

Name: _____
Address: _____
Phone: (____) _____ - _____ Relationship: _____

I understand that the information provided is accurate and true. I give consent to contact any individuals listed above for the purpose of reviewing my application.

Signature: _____
Date: ____ / ____ / ____

Applications may be emailed to: **HopeHouse@norcen.org**
For questions, please call: **715-470-1563**

If mailing, send to:

North Central Health Care
Attn: Hope House
1150 Lake View Drive
Wausau, WI 54403