

## Hope House Participant Application

Name \_\_\_\_\_

Age \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sobriety Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

House applied for \_\_\_\_\_

Home/last address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

City/County of residence? \_\_\_\_\_

Cell phone number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Last treatment/halfway house \_\_\_\_\_

Number of treatment programs \_\_\_\_\_ In how many years? \_\_\_\_\_

What is the longest time period you have been clean and sober? \_\_\_\_\_

What was the reason for your relapse? \_\_\_\_\_

Current Counselors Name \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Sponsor or Mentor Name \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Drug(s) of choice \_\_\_\_\_

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

If yes, Name of officer \_\_\_\_\_ Phone number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Are you currently in any other treatment services? Y N

If yes, what services are you receiving? \_\_\_\_\_

Name of Service \_\_\_\_\_

Phone number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Current Employer \_\_\_\_\_

Name of Supervisor \_\_\_\_\_

Phone number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Married / Single      Kids   Y   N   How many dependents? \_\_\_\_\_

Where do your dependent children live? \_\_\_\_\_

Does addiction run in your family? Y   N

Who in your family has addiction problems? \_\_\_\_\_

How many of those family members are in Recovery? \_\_\_\_\_

Do any of your family members participate in support groups  
such as Al-Anon/Teen? Y   N

What kind of support system do you have in place?

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Would you have a safe housing option if Sober Living did not have a spot open?  
If so where?

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Other pertinent information you feel is necessary for us to know:

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**Personal References**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

**\*I understand that the information given is accurate and true. Also, I give consent to contact any persons whose names are provided to gain information regarding my application.**

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Applications may be emailed to: [HopeHouse@norcen.org](mailto:HopeHouse@norcen.org)

Any questions please call 715-470-1563

If necessary to mail application, please send to:

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