



North Central Health Care

Person centered. Outcome focused.

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? _____



North Central Health Care

Person centered. Outcome focused.

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?

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

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

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: Heather Gustafson at Hgustafson@norcen.org.

Any questions please call 715.370.9823.

If necessary to mail application, please send to:

North Central Health Care
Attn: Hope House
2400 Marshall Street, Suite A
Wausau, WI 54403