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_______/_______/_______

If necessary to mail application, please send to:

North Central Health Care
Attn: Hope House
1100 Lake View Drive,
Wausau, WI 54403