



**This application is for internal uses only.** The questions are designed to assist Voices of Hope in utilizing our resources to assist you in your recovery through accountability and aiding you in any obstacles you may need to overcome. **Please be advised that a background check will be conducted. Signing this application gives us permission to do so.**

Print Name (First, Middle, Last) ( <b>Full Legal Name</b> )	Date of Birth: Recovery Date:
Marital status ( <b>Circle One</b> ) <b>Single Married Divorced</b>  Do You Have Children: <b>Yes or No</b>  How Many Children:	Information Where You Can Be Reached  Cell: _____  Email: _____
<b>Emergency Contact:</b>  Name: _____  Relation: _____  Phone Number:	<b>Identification Numbers</b>  SSN#: _____ Driver's License/ID on you: <b>Yes or No</b> Is it valid? <b>Yes or No</b> State _____ Birth Certificate on you: <b>Yes or No</b> Soc Sec Card on you: <b>Yes or No</b>
Do you have your own vehicle? <b>Yes or No</b>	
Please list all current medications:	

<p>Do you have Health Insurance? <b>Yes or No</b>  Do you have Health Insurance card on you?  <b>Yes or No</b></p>	<p>Are you getting SSI, Disability or other non job-related income? <b>Yes or No</b></p>
<p>Are you currently employed? <b>Yes or No</b>  Where?</p>	<p>Work Schedule:(Days and hours)</p>
<p>Willing to volunteer if needed? <b>Yes or No</b>  Willing to obtain a sponsor/ mentor? <b>Yes or No</b></p>	<p>Are you discharging from a substance abuse treatment program? <b>Yes or No</b>  <b>(Please Use boxes Below)</b></p>
<p><b><u>If Yes:</u></b>  Facility Name: _____  Case Manager Name: _____  Phone Number: _____  Email: _____  Discharge Date: _____</p>	<p><b><u>If No:</u></b>  Location: _____  Address: _____  City: _____  State: _____  Zip: _____  Move in Date: _____</p>
<p>Are you participating in or about to enter a methadone or other Medicated Assisted Treatment program? <b>Yes or No</b> Which one:</p>	

<p>Do you have any current court cases pending, other than moving violations? <b>Yes or No</b></p>	<p>Have you ever been convicted of a felony? <b>Yes or No</b></p>
<p><b><u>If Yes:</u></b>  Violation:  Please circle:  <b>Probation, Bond, Drug Court or Pending Court Case</b>  County: _____  City: _____ State: _____</p>	<p><b><u>If Yes,</u></b> explain:</p>

How long have you been in active addiction?
What is your longest period of recovery to date?
Do you have a history of inpatient treatment?
Are you living/have you lived in a Sober Living Home before? <b>Yes or No</b> Which one?
Are you required to register as a sex offender? <b>Yes or No</b>
Are you willing to sign release of info forms with your Doctors, IOP, Employers, Courts? <b>Yes or No</b>
What is your biggest challenge in Recovery?
What do you hope to accomplish by living at Voices of Hope Recovery House?
Do you have any religious practices we should know about?
Do you have any food allergies? <b>Yes or No</b> If yes please list:
Will you need food stamps? <b>Yes or No</b> Do you have your food stamp card on you? <b>Yes or No</b>
Will you need a cell phone? <b>Yes or No</b>
Willing to meet with Peer Recovery Specialist Weekly? <b>Yes or No</b>
Are you willing to complete a recovery plan with a peer? <b>Yes or No</b>
Are you willing to complete a WRAP Plan(Wellness Recovery Action Plan)? <b>Yes or No</b>

Can you think of anything else you may need?

Can you think of anything that may be an obstacle for you while living at Voices of Hope Residence?

Please list individuals who support you in your recovery (name, number, and relationship):

By signing the application below, I authorize Voices of Hope Recovery House Program to utilize the above information to process my request for acceptance.

**Printed Name of Applicant:** \_\_\_\_\_

**Signature of Applicant:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please email application to [stephenhawkins@voicesofhopemaryland.org](mailto:stephenhawkins@voicesofhopemaryland.org)

If you have any questions feel free to call 443-993-7055 EXT. 4