

Foundations Recovery House

Building Better Lives

Extended Recovery Residency Application

An electronic version of this application is available on our website at:

<https://wwwFOUNDATIONSRECOVERYHOUSE.COM/apply-now>.

Personal Information				
Print Your Full Name (First, Middle, Last)		Date of Birth	Age	
Phone	Contact Person & Phone Number (Family, Discharge Coordinator, Peer Support, etc.)		Gender <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> T	
Email				
Current Address		City	State	Zip
Social Security #	Marital Status	Do You Have Children? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, List Names & Ages	
Referred By: <input type="checkbox"/> Family/Friend <input type="checkbox"/> Employer/Coworker <input type="checkbox"/> Treatment or Human Services Professional <input type="checkbox"/> Representative of Court/Judicial System <input type="checkbox"/> No One <input type="checkbox"/> Other _____		If Referred, Provide Name of Referring Person(s).	Requested Residency Entry Date	
Where will you be coming from?				
Driver Information				
Valid Driver's License <input type="checkbox"/> Yes <input type="checkbox"/> No	State	Driver's License #		
Own a Vehicle <input type="checkbox"/> Yes <input type="checkbox"/> No	Year/Make/Model		License Plate #	

Foundations Recovery House

Building Better Lives

Recovery Information

Date of Last Use		Primary Substance (check one) <input type="checkbox"/> Alcohol <input type="checkbox"/> Hallucinogen <input type="checkbox"/> Amphetamines <input type="checkbox"/> Marijuana <input type="checkbox"/> Benzoids <input type="checkbox"/> Opiates <input type="checkbox"/> Cocaine <input type="checkbox"/> Other		Primary Substance Route of Administration (check one) <input type="checkbox"/> Not Applicable <input type="checkbox"/> Inhalation <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Smoking <input type="checkbox"/> Other	
Any IV Drug Use <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Substance Age of First Use		Have You Ever Relapsed <input type="checkbox"/> Yes <input type="checkbox"/> No	
Currently/Recently in Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No		Name/Location of Facility		Completed Successfully <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do You Attend 12-Step Meetings? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, How Often?		Do You Have a Sponsor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Have You Lived in a Recovery Residence Before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prior Recovery Residence(s), Length of Residency, & Reason for Leaving					
Why Do You Want to Live at Foundations Recovery House?					

Employment Information

Are You Currently Employed? <input type="checkbox"/> Employed Full-Time (35+ hours per week) <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Unemployed and Looking for Work <input type="checkbox"/> Unemployed and Not Looking for Work (e.g. retired, disabled, school, etc.) <input type="checkbox"/> Other _____		If Yes, Name & Location of Employer			
Job Title		Length of Employment		Current Monthly Income	
If No, How Long Since Last Employed?		Are You Willing to Find Employment Within 30 Days? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are You Willing to be Self-Supporting? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What Type of Work Have You Done?			What is the Highest Level of Education Completed? <input type="checkbox"/> Less than High School <input type="checkbox"/> 2-Year College Degree <input type="checkbox"/> High School Graduate/GED <input type="checkbox"/> 4-Year College Degree <input type="checkbox"/> Vocational Degree <input type="checkbox"/> Masters or PhD <input type="checkbox"/> Some College		

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Building Better Lives

Employment Information (continued)		
Currently Enrolled in School or Job Training Program? <input type="checkbox"/> Not Enrolled <input type="checkbox"/> Enrolled Part-Time <input type="checkbox"/> Enrolled Full-Time <input type="checkbox"/> Other _____	Military Service <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, What Branch & Type of Discharge?
Special Skills/Training	How Will You Pay for Your Weekly Extended Recovery Residence Fee? (self-pay, funding, etc.)	
Legal Information		
List Pending Charges/Cases/Warrants		Arrest History
Have You Ever Been Incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, When/How Long?	Reason for Incarceration?
Name & Location of Facility		Currently on Probation/Parole? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Location of Office, Name of Officer, & Contact Phone		Are You a Registered Sex Offender? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have You Ever Been Convicted of a Sexual or Violent Crime? <input type="checkbox"/> Yes <input type="checkbox"/> No	List All Convictions	
Medical Information		
Previous Diagnosis (check all that apply) <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Mood/Personality Disorder		Any Psychiatric or Medical History (including specific details of items checked)?
History of Self Harm? <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Suicidal or Homicidal Ideation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Describe
Are You Currently Taking Any Medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, List All Medications	
Describe Any Injuries/Disabilities		Describe Physical Limitations Resulting from Injuries/Disabilities
Are You Physically Able to Use a Top Bunk? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name & Phone of Primary Care Physician
Are You Receiving Suboxone, Subutex, Methadone, Vivitrol, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Which One?	If Yes, Prescribing Physician

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Emergency Information

Emergency Contact Name (First & Last)	Emergency Contact Relationship	Emergency Contact Phone Number	
Emergency Contact Address	City	State	Zip

General Information

How Would You Rate Your Current Quality of Life? <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Neither Good nor Poor <input type="checkbox"/> Poor <input type="checkbox"/> Very Poor	Is Your Family Supportive of Your Recovery Efforts? <input type="checkbox"/> Very Supportive <input type="checkbox"/> Supportive <input type="checkbox"/> Neither Supportive nor Unsupportive <input type="checkbox"/> Unsupportive <input type="checkbox"/> Very Unsupportive
What Would You Like to Accomplish During Your Stay at Foundations Recovery House?	
If Accepted into our Program, What are Three (3) Goals You'd Like to Achieve While at Foundations Recovery House and Why Are They Important to You?	
What Potential Challenges Do You See in Improving Your Recovery?	
What Else Would Be Helpful for Us To Know About You To Best Serve You?	