

Application for Residence at TE Recovery

Date of Application:		Date Requesting Residency:	
PERSONAL INFORMATION			
Full Name		Date of Birth	Age
Phone	Email		
Social Security #	Marital Status	Current Living Situation	
Current Address		City	State Zip
Own a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	Year/Make/Model		License Plate #
Valid Driver License? <input type="checkbox"/> Yes <input type="checkbox"/> No	State	Driver License #	
RECOVERY INFORMATION (Dx: Verified by: _____)			
Alcohol Use Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Opiate Use Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Substance Use Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last use:
Currently/recently in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name & Location of Facility		
Did you complete successfully? <input type="checkbox"/> Yes <input type="checkbox"/> No	Discharge Date	Name of Counselor	
Drug(s) of Choice			
Who referred you to ? (Name, Relationship & Phone)			
Do you attend 12-step meetings? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, how often?		Do you have a sponsor? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you lived in a recovery house before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name & Location of House		When/How long?
Why did you leave there?			
How can TE Recovery be of service to you; What are you looking for in a recovery house?			
EMPLOYMENT INFORMATION			
Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name & Location of Employer		Job Title How long employed?
Are you on gov't disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain the disability:		
Current Monthly Income	What other types of work have you done?	Special Skills/Training	

If No, how long since you were last employed?	Are you willing/able to get a job within 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you willing/able to be self-supporting? <input type="checkbox"/> Yes <input type="checkbox"/> No
Will someone else be helping you pay rent or deposit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name/Relationship	Phone
Street Address	City	State Zip

LEGAL INFORMATION

List Pending Charges/Cases/Warrants

Have you ever been incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No	When/How Long?	Reason	Name & Location of Facility
Currently on probation/parole? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason	Location of Office	
Name of Officer	Contact Phone		
List Felony Convictions			
Are you a registered sex offender? <input type="checkbox"/> Yes <input type="checkbox"/> No			

MEDICAL INFORMATION

List All Medical/ Psychiatric Conditions	List All Current Medications
Describe Any Injuries/Disabilities	
Describe Physical Limitations	
Name of Physician	
Are you receiving Suboxone, Subutex, Methadone, Vivitrol, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list medications	Physician Prescribing

EMERGENCY CONTACTS (LIST TWO)

Name	Relationship	Phone
Street Address	City	State Zip
Name	Relationship	Phone
Street Address	City	State Zip

I have read and agree to all house rules and that the information in this application is true. (signature & date required).

