



SOBER CROSSINGS

APPLICATION FOR RESIDENCY

Please answer all questions thoroughly to the best of your ability. Any false information or failure to disclose pertinent information may be grounds for immediate termination. This information is confidential and only for use by Sober Crossings.

DATE: _____

BACKGROUND INFORMATION:

NAME: _____

PREVIOUS STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #1:(_____) _____ PHONE #2:(_____) _____

AGE: _____ BIRTHDATE: _____ SOC. SECURITY #: _____

MARRIED STATUS: MARRIED/COHABITATING DIVORCED SINGLE

EMERGENCY INFORMATION:

EMERGENCY CONTACT: _____

PHONE NUMBER:(_____) _____ RELATIONSHIP: _____

EMPLOYMENT:

DO YOU HAVE A JOB?: YES NO FULL TIME PART TIME

IF NO, WHAT ARE YOU DOING?: _____

OCCUPATION: _____

EMPLOYER: _____ SUPERVISOR: _____

ADDRESS: _____

WORK PHONE NUMBER:(_____) _____

HOW LONG HAVE YOU BEEN EMPLOYED?: _____

IF YOU DO NOT HAVE A JOB OR UNABLE TO PAY FOR ANY REASON, WHO CAN AND/OR WILL YOU BE ABLE TO PAY YOUR WEEKLY FEE?:

NAME: _____

PHONE:(_____) _____ RELATIONSHIP: _____

CRIMINAL HISTORY:

ARE YOU CURRENTLY ON PROBATION OR PAROLE?: YES NO

IF YES, PROBATION/PAROLE OFFICER'S NAME: _____

STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COURT: _____

PHONE:(_____) _____ FAX:(_____) _____

WHAT IS YOUR CURRENT OFFENSE AND STATUS?: _____

PLEASE LIST ANY STIPULATIONS FOR PROBATION OR PAROLE:

HAVE YOU EVER BEEN CONVICTED OF ARSON?: YES NO

IF YES, PLEASE EXPLAIN: _____

HAVE YOU EVER BEEN CONVICTED OF A SEXUAL ASSAULT?: YES NO

IF YES, PLEASE EXPLAIN: _____

MEDICAL INFORMATION:

DO YOU HAVE ANY MEDICAL CONDITIONS?: YES NO

IF YES, PLEASE LIST ALL MEDICAL CONDITIONS: _____

DO HAVE A PRIMARY CARE PHYSICIAN (PCP)?: YES NO

DOCTORS NAME: _____

STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE:(_____) _____ FAX:(_____) _____

ARE YOU TAKING ANY CURRENT PRESCRIBED MEDICATIONS?: YES NO

IF YES, PLEASE LIST:

MEDICATION	DOSE	REASON

SUBSTANCE ABUSE INFORMATION:

PLEASE LIST IN ORDER OF PREFERENCE ALL DRUGS/ALCOHOL USED:

DRUG/ALCOHOL	AMOUNT USED	DATE LAST USED
1.		
2.		
3.		
4.		

RECOVERY INFORMATION:

HOW MANY DAYS HAVE YOU BEEN SOBER?: _____

DO YOU CURRENTLY HAVE A SPONSOR?: YES NO

IF YES, NAME: _____ PHONE:(_____) _____

ARE YOU COMING FROM A TREATMENT PROGRAM/SOBER HOUSE? YES NO

IF YES, WHICH ONE?: HALFWAY HOUSE DETOX OUTPATIENT SOBER

IF YES, NAME: _____

ADDRESS: _____

FOR HOW LONG?: _____

WHY DID YOU LEAVE?: _____

ARE YOU WORKING OR WILLING TO WORK THE 12 STEPS? YES NO

ARE YOU CURRENTLY ATTENDING ANY AA OR NA MEETINGS? YES NO

IF YES, HOW MANY PER WEEK?: _____

WHAT ARE YOUR PLANS FOR RECOVERY?: _____

IF ACCEPTED, WHAT IS YOUR ANTICIPATED MOVE-IN DATE?: _____

AFFIRMATION:

I affirm that my answers and information provided by me in this application are true and accurate. In order to process my application, I give Sober Crossings consent to verify the information I provided as needed. I understand that if I am accepted, any misinformation and/or dishonest answers that were given may be grounds for my dismissal.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____ DATE: _____

FOR HOUSE USE ONLY

Application Accepted: Yes No Date: _____ Move-In Date: _____
Move Out Date: _____ Reason for Departure: _____
House Key(s) Returned: Yes No
Outstanding Debt to Sober Crossings: None Yes \$ _____ For: _____