House of Transformations

Resident Application Desired Move-in Date: _____

1. APPLICANT INFORMATION

Full Name: _____ Date of Birth: _____

Sex: ☐ M ☐ F Social Security # _____

Address: _____
Street Address – If in prison, give prison address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

What is your preferred contact method? TEXT ☐ PHONE ☐ E-MAIL ☐ US MAIL ☐

Do we have your permission to contact you using this method? YES ☐ NO ☐

Are you a U.S. Citizen? YES ☐ NO ☐

Are you an Alaska Resident? YES ☐ NO ☐

Have you ever been known by an alternate name? YES ☐ NO ☐ If yes, what alternate name? _____

2. CRIMINAL HISTORY

Have you ever been charged with or convicted of a Felony? ☐ YES ☐ NO

Are You Required to register as a Sex Offender? ☐ YES ☐ NO

►List Felony or SO Charges: _____

Are there any Restraining Orders against you or by you? ☐ YES ☐ NO

►If "Yes", please explain: _____

Check all legal restrictions that currently apply to you: PROBATION ☐ PAROLE ☐ HOUSE ARREST ☐ DRUG COURT ☐ P.E.D ☐ E.M. ☐ N/A ☐

►Please Explain: _____

_____

_____

***If you have a Parole, Probation, and/or a P.E.D. Officer, add their information in the "Contacts" section**

Do you have any possible jail time or upcoming sentencing possible? YES ☐ NO ☐

Do you have any Community Service Requirements? YES ☐ NO ☐

Do you have any Court Ordered Treatment Requirements? YES ☐ NO ☐

Have you ever been charged with or convicted of abuse of any Person (Child, Senior, Disabled, etc.)? YES ☐ NO ☐

Are you a member of any gang? YES ☐ NO ☐

►Please Describe any "Yes" Answers: _____

_____

_____

3. ADDICTION HISTORY

What are your Primary Drugs of Choice? (Check all that apply)

☐ Meth ☐ Heroin ☐ Cocaine ☐ Alcohol ☐ THC ☐ PCP ☐ LSD ☐ Mushrooms

☐ MDMA ☐ Oxy ☐ Inhalants ☐ K2 ☐ Other: _____

What were the last drugs you used and when? _____

How many years have you been using? _____

What is your Sober / Clean date? _____

Do you have a Sponsor? ☐ YES ☐ NO (If "Yes", Please add their information in the "Contacts" Section)

Do you use tobacco? ☐ YES ☐ NO If "YES", would you like to quit? ☐ YES ☐ NO

If "YES", do you need help quitting? ☐ YES ☐ NO

Do you have any other addictions (Gambling, Money, Sex, Internet, etc.?) ☐ YES ☐ NO

►If "Yes", Please Explain: _____

_____

TREATMENT HISTORY

Are you currently in another treatment program? ☐ YES ☐ NO

Name of Program: _____ Program Start Date: _____/_____/_____

What type of program is it? In-Patient ☐ Out-Patient ☐ Sober Living ☐ Est. Discharge Date: _____/_____/_____

Describe any aftercare plans: _____

Have you previously been through any other treatment programs? ☐ YES ☐ NO

Most recent program: _____ Approximate Start Date: _____/_____/_____

Length of Stay: _____ Resulting length of sobriety: _____

What type of program was it? ☐ In-Patient ☐ Out-Patient ☐ Sober Living

Why did you leave the program? Graduated ☐ AWOL ☐ AMA ☐ Rules Violation ☐ Other ☐

Previous program: _____ Approximate Start Date: _____/_____/_____

Length of Stay: _____ Resulting length of sobriety: _____

What type of program was it? ☐ In-Patient ☐ Out-Patient ☐ Sober Living

Why did you leave the program? Graduated ☐ AWOL ☐ AMA ☐ Rules Violation ☐ Other ☐

Previous program: _____ Approximate Start Date: _____/_____/_____

Length of Stay: _____ Resulting length of sobriety: _____

What type of program was it? ☐ In-Patient ☐ Out-Patient ☐ Sober Living

Why did you leave the program? Graduated ☐ AWOL ☐ AMA ☐ Rules Violation ☐ Other ☐

4. MEDICAL / MENTAL HEALTH

MEDICAL

Do you have any allergies? ☐ YES ☐ NO

Do you have any physical health / medical conditions or disabilities? ☐ YES ☐ NO

Do you have HIV/AIDS or any form of Hepatitis? ☐ YES ☐ NO

Do you have any upcoming medical appointments or ongoing physical needs? ☐ YES ☐ NO

►If so, please describe: _____

_____

_____

Are you at risk for exposure to any communicable diseases, or been in contact with someone who has? YES ☐ NO ☐

Have you traveled outside the country in the last 30 days? ☐ YES ☐ NO

►If "YES", where? _____

CORONAVIRUS

Are you experiencing shortness of breath? ☐ YES ☐ NO

Do you have a cough or a fever? ☐ YES ☐ NO

Do you have any other symptoms of Coronavirus and/or a flu? ☐ YES ☐ NO

►If "YES" to any of the above symptoms, have you been tested for the Coronavirus? ☐ YES ☐ NO

►►If you have not been tested, are you willing to be tested? ☐ YES ☐ NO

Please describe any testing results, dates, or unwillingness to be tested: _____

_____

MENTAL HEALTH

Do you have a need for Mental Health Services? ☐ YES ☐ NO

►If "YES", please describe: _____

_____

Do you have any Mental Health issues or diagnosis? ☐ YES ☐ NO

►If "YES", please describe: _____

_____

Have you ever experienced any suicide ideations or attempts? ☐ YES ☐ NO

Have you ever received in-patient treatment for self-harming behaviors? ☐ YES ☐ NO

Do you have an eating disorder or body-image disorder? ☐ YES ☐ NO

►Please describe any "YES" answers: _____

_____

Have you ever been a victim of sex trafficking? ☐ YES ☐ NO

►If "YES", please describe: _____

_____

_____

4. MEDICAL / MENTAL HEALTH (Continued)

MEDICATIONS

Are you taking any prescription medications? ☐ YES ☐ NO

►If "YES", please provide the following details

Rx Name (1): _____ Use: _____ Dosage: _____ Pill Count: _____

Rx Name (2): _____ Use: _____ Dosage: _____ Pill Count: _____

Rx Name (3): _____ Use: _____ Dosage: _____ Pill Count: _____

*If you have more medications to add, please write them in at end of application

Are you taking any Over the Counter (OTC) medications? ☐ YES ☐ NO

►If "YES", please provide the following details

OTC Name (1): _____ Use: _____ Dosage: _____ Pill Count: _____

OTC Name (2): _____ Use: _____ Dosage: _____ Pill Count: _____

OTC Name (3): _____ Use: _____ Dosage: _____ Pill Count: _____

*If you have more medications to add, please write them in at end of application

Are you participating in, or interested in, any drug replacement program? CURRENT PARTICIPANT ☐ WOULD LIKE TO PARTICIPATE ☐ N/A ☐

*Commonly referred to as Medication Assisted Therapy (MAT)

Which type of program? VIVITROL / ReVIA ☐ SUBUTEX ☐ METHADONE ☐ SUBOXONE ☐ SUBLOCADE ☐ OTHER ☐

***If you currently participate in one of these programs, please add your "MAT Doctor" information in the "CONTACTS" section**

5. FINANCIAL

Transitional Housing beds are $22.50 to $27/night depending on intake criteria.
You will be notified of your daily rate upon approval / acceptance into program.

How will you pay for the program? SELF-PAY ☐ FRIEND/FAMILY ☐ INSURANCE ☐ OTHER ☐

►If "Other", please describe: _____

***If payer is anyone other than yourself, please add details in "CONTACTS" section**

Do you receive Social Security Disability payments? ☐ YES ☐ NO

►If "YES", what is the yearly amount? $_____ / year

EMPLOYMENT

Are you willing to work 40 hours a week of gainful employment? ☐ YES ☐ NO

Are you currently employed? ☐ YES ☐ NO

►If "NO", are you currently seeking employment? ☐ YES ☐ NO

►Are you willing to complete a minimum of 2 applications per day? ☐ YES ☐ NO

►►Please describe any skills or industry experience that would help you find a job: _____

_____

_____

***If you are currently employed, please add employer information in the "CONTACTS" section**

Are you interested in Vocational Training (CDL, Beauty/Barber, Substance Abuse Counselor, or Renewable Energy)? ☐ YES ☐ NO

►If "YES", which one(s): _____

6. FAMILY & FRIENDS

What is your Marital Status? SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ OTHER ☐

***If you are married or have a significant other, please put their information in the "CONTACTS" section**

Are you in the process of Family Reunification? ☐ YES ☐ NO

►If "YES", please describe: _____

Do you have any children? ☐ YES ☐ NO

►Please describe (how many, ages, etc.): _____

►Do you have legal custody of your children? ☐ YES ☐ NO

*Legal custody means that you have been to court and have paperwork

►Do you have an open case with the Office of Children's Services? ☐ YES ☐ NO

►►Please Describe: _____

►Do you have a Child Support Obligation? ☐ YES ☐ NO

►►If so, how much? $ _____ / month

***If you have an OCS Case Worker assigned to your case, please put their information in the "CONTACTS" section**

Do you have a personal relationship with any House of Transformations **employee**? ☐ YES ☐ NO

►If "YES", please describe: _____

Do you have a personal or intimate relationship with any of our **current residents**? ☐ YES ☐ NO

►If "YES", please describe: _____

Are you fleeing a Domestic Violence (DV) situation? ☐ YES ☐ NO

►If "YES", please describe: _____

_____

_____

►Have you notified the Authorities about your DV situation? ☐ YES ☐ NO

►►If not, do you need help notifying them? ☐ YES ☐ NO

***If you would like more assistance with this, and you have a DV Case Worker, please provide their information in the "CONTACTS" section**

7. MISCELANEOUS

Are you a Veteran? ☐ YES ☐ NO

Do you have any shares in a Native Corporation? ☐ YES ☐ NO

►If "YES", which Native Corporation(s)? _____

What is your highest level of education? G.E.D. ☐ H.S. DIPLOMA ☐ ASSOC. DEGREE ☐ VOCATIONAL SCHOOL ☐ COLLEGE ☐ NO G.E.D OR H.S. DIPLOMA ☐

What is your primary mode of transportation?

OWN CAR ☐ FRIEND / FAMILY ☐ PUBLIC TRANSPORT ☐ OTHER: _____ ☐

***If you intend on parking a vehicle on H.O.T. property, you must first provide proof of registration and insurance**

8. ASSISTANCE / HELP

What is your primary language? ☐ English ☐ Other: _____

Do you have a learning disability or difficulty reading? ☐ YES ☐ NO

►If "YES", please describe: _____

Are you able to perform household chores? ☐ YES ☐ NO

Are you able to share a room? ☐ YES ☐ NO

►If not, please explain: _____

_____

Do you need help renewing any forms of ID? (S.S. card, Birth Cert, State ID, etc.) ☐ YES ☐ NO

Do you need help signing up for Medicaid or Food Programs? ☐ YES ☐ NO

►Please describe which forms of ID or programs you need help with: _____

_____

Do you have any other **immediate** needs such as clothing, toiletries, or food? ☐ YES ☐ NO

►Please describe immediate needs: _____

_____

8. WHY

Who referred you to the House of Transformation? _____

What issues led you to seek housing with us? _____

_____

_____

_____

_____

_____

_____

_____

If you are accepted into our program, what would be your goals and expectations? _____

_____

_____

_____

_____

_____

_____

_____

_____

***Please use additional sheets if you need more room to answer these questions**

9. CONTACTS

P.E.D. OFFICER ☐ N/A

Name: _____ Approximate Trial Date: _____

Cell Phone # _____ E-mail: _____

Office Phone # _____ Is this person an emergency contact? ☐ YES ☐ NO

Can we contact this person regarding your application? **(Required)** ☐ YES ☐ NO

PROBATION OFFICER ☐ N/A

Name: _____ Length of Probation: _____

Cell Phone # _____ E-mail: _____

Office Phone # _____ Is this person an emergency contact? ☐ YES ☐ NO

Can we contact this person regarding your application? **(Required)** ☐ YES ☐ NO

PAROLE OFFICER ☐ N/A

Name: _____ Length of Parole: _____

Cell Phone # _____ E-mail: _____

Office Phone # _____ Is this person an emergency contact? ☐ YES ☐ NO

Can we contact this person regarding your application? **(Required)** ☐ YES ☐ NO

NOTE:
IF WE DO NOT RECEIVE YOUR PERMISSION TO CONTACT YOUR PAROLE, PROBATION, OR P.E.D. OFFICER, YOUR APPLICATION WILL BE DENIED

O.C.S. CASE WORKER ☐ N/A

Name: _____ Case Reference #: _____

Phone # _____ E-mail: _____

Is this person an emergency contact? ☐ YES ☐ NO

Can we release your information to this person? ☐ YES ☐ NO

D.V. CASE WORKER ☐ N/A

Name: _____ Case Reference #: _____

Phone # _____ E-mail: _____

Is this person an emergency contact? ☐ YES ☐ NO

Can we release your information to this person? ☐ YES ☐ NO

A.A. / N.A. SPONSOR ☐ N/A

Name: _____ Length of Sponsorship: _____

Phone # _____ E-mail: _____

Length of Sobriety: _____ Is this person an emergency contact? ☐ YES ☐ NO

Can we release your information to this person? ☐ YES ☐ NO

M.A.T. DOCTOR ☐ N/A

Doctor's name: _____ Clinic name: _____

Phone # _____ E-mail: _____

Length of relationship: _____ Is this person an emergency contact? ☐ YES ☐ NO

Can we release your information to this person? **(Required)** ☐ YES ☐ NO

9. CONTACTS (Continued)

CURRENT EMPLOYER ☐ N/A

Boss's name: _____ Business name: _____

Phone # _____ E-mail: _____

Length of employment: _____ Is this person an emergency contact? ☐ YES ☐ NO

Can we release information to this person? ☐ YES ☐ NO

SPOUSE / SIGNIFICANT OTHER ☐ N/A

Name: _____ Relationship: _____

Phone # _____ E-mail: _____

Length of relationship: _____ Is this person an emergency contact? ☐ YES ☐ NO

Can we release information to this person? ☐ YES ☐ NO

PAYER SOURCE (If other than yourself)

Contact Name: _____ Relationship: _____

Phone # _____ E-mail: _____

Is this person an emergency contact? ☐ YES ☐ NO

Can we release your information to this person? **(Required)** ☐ YES ☐ NO

►If you're using insurance:

Insurance Company Name (EXACT name from card): _____

Plan Name: _____ Claims Phone # _____

Group ID: _____ Member ID: _____ Card Issue Date: _____

Are you the Policy Holder? ☐ YES ☐ NO

►►If not, please enter Policy Holder information:

Name: _____ Relationship to you: _____

D.O.B. _____ Phone # _____ E-mail: _____

Address: _____

Can we release your information to this person? **(Required)** ☐ YES ☐ NO