

# Appendix

## Appendix A: Application Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Identified Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ State: \_\_\_\_\_

Have you lived in a halfway house? When? Where? \_\_\_\_\_

Do you have a payee? (name and address) \_\_\_\_\_

Do you receive SSI or Disability payments? Yes \_\_\_\_\_ No \_\_\_\_\_ Type: \_\_\_\_\_

What is your highest level of education? High School Graduate \_\_\_\_\_

GED \_\_\_\_\_ College \_\_\_\_\_ Other \_\_\_\_\_

Where did you live before moving here? (City, State) \_\_\_\_\_

What is your source of Income? \_\_\_\_\_

Are you employed? If yes, what kind of work do you do? \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Hours: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Enrolled in School Full-Time/Part-Time: \_\_\_\_\_

Name of School: \_\_\_\_\_

What is your means of transportation: \_\_\_\_\_

Have you lived in a Sober Living Home before? (When/Where) \_\_\_\_\_

Do you have any medical issues that would impede your recovery or prevent you from being able to live by yourself? \_\_\_\_\_

What kind of medical problems (physical or emotional) do we need to know about you?

Do you have any allergies? \_\_\_\_\_

Do you have any chronic conditions or communicable diseases? \_\_\_\_\_

Medications presently taking? \_\_\_\_\_

Addictions or compulsive behaviors you have: \_\_\_\_\_

Drug(s) of choice? \_\_\_\_\_

Date of last use? \_\_\_\_\_ # of relapses in the past year? \_\_\_\_\_

Treatment program completed: \_\_\_\_\_

Counselor/Caseworker: \_\_\_\_\_

After-care requirements: \_\_\_\_\_

Drug Treatment Plan? \_\_\_\_\_

Have you received any DUI's or DWI's? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many? \_\_\_\_\_

Do you have problems with rules or authority? \_\_\_\_\_

Are you prejudiced towards any group or race? \_\_\_\_\_

Have you ever considered suicide? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how long ago? \_\_\_\_\_

If you answered yes to the previous question, do you agree to enter into a plan of action, if needed? Yes \_\_\_\_\_ No \_\_\_\_\_

Veteran: \_\_\_\_\_ Branch: \_\_\_\_\_

Probation/Parole: \_\_\_\_\_ End Date: \_\_\_\_\_

Probation Officer's Name: \_\_\_\_\_

City & County: \_\_\_\_\_ PO's Phone: \_\_\_\_\_

Court Case/Charges Pending: \_\_\_\_\_

Have you ever been ARRESTED for a sex crime or arson? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? \_\_\_\_\_

Felony convictions (what, where, and when): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Conditions of entry: \_\_\_\_\_

Sex offenses, violent offenses, mental health conditions, and active psychosis may result in an exclusion of admission to Keystone Recovery Center.

**Who to call in case of an emergency:**

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Email Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Email Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Email Address: \_\_\_\_\_

**Medicaid, Medicare or insurance information if applicable in case of emergency:** \_\_\_\_\_

\_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **To be completed by Keystone Recovery:**

### **Exclusionary Criteria:**

- Resident is not on the sex offender registry
- Resident has not been convicted of any violent offenses
- Resident does not have mental health conditions that contraindicate this low level of care
- Resident scored LOW risk on the suicide risk assessment (moderate or high-risk on suicide will need written medical/clinical clearance before entry into Keystone Recovery Center)

**(House Manager) I have verified that the Applicant does not meet exclusionary criteria**

### **Eligibility requirements:**

- Must be clean from alcohol and drugs for 30 days
- Not presenting with a current clinical assessment that contradicts this level of care
- Pass UA
- 18 years of age or older (verified) by driver's license or other form of ID
- Physically able to walk stairs and prepare their own meals,
- First 2 weeks rent

**(House Manager) I have verified that the Applicant meets the eligibility criteria**

KRC House Manager Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_