Recovering Hands Application

Applicant Information

Name:		
Date of birth:	SSN:	
Phone Number:	Email Address:	
Last address:		
City:	State:	ZIP Code:

Emergency Information

Contact name in the event of an emergency:	
Relationship:	Phone number:
Address:	Email address:

Treatment History

How many times have you been in residential treatment?

Name of your last treatment center:

Did/will you successfully complete treatment? YES NO. If no, please share details:

Name of your last recovery residence, if applicable:

Did you successfully complete the recovery residency program? YES NO.
If no, please share details:

Recovery History

Prior to entering treatment the last time, what was your longest period of recovery?

What recovery support fellowship do you prefer? NA AA Faith Based Other :

Are you willing to attend 90 meetings in 90 days? YES NO

If no, please share more:

What reasons do you have for wanting to be at Recovering Hands?

What reservations do you have about being at Recovering Hands?

Are family and/or significant others supportive of your participation in a recovery residence at this time?

What are your biggest motivations to live a full life in recovery?

Legal History

Do you have pending legal charges? NO	YES	Upcoming court date? If so, when?
Are you on deferred prosecution? NO	YES	If so, in which county/state?
Are you on probation? NO	YES	If so, in which county/state?
Any prior charges of assault? NO	YES	If so, please share more on a separate sheet.
Any prior charges of sexual violence? NO	YES	--- same ----
Are you a registered sex offender? NO	YES	---same ----
Any history of arson? NO	YES	---same ----
Any history of burglary? NO	YES	---same ----
Ever been convicted of a felony? NO	YES	

Financial	
Are you currently employed? YES NO	Employer:
If so, what is your work schedule?	
Do you plan to pay your own fees? YES NO	
Name of your guarantor for fees:	Relationship:
Guarantor phone number:	Guarantor email address:
Guarantor address:	City/State/Zip:

Transportation
Do you currently have privileges to drive in the State of VA? YES NO
Will you be driving yourself here? YES NO

Medical
Do you have any medical conditions that may interfere with employment or successful transitional care? YES NO If yes, please share more on a separate sheet.
List of all current medications, including over-the-counter medications:
Have you ever been hospitalized for a primary psychiatric condition? YES NO. If yes, please share more on a separate sheet.
History of suicide attempts? YES NO
Did you receive medical care as a result? YES NO If yes, please share more on a separate sheet.
Approximately how long has it been since you experienced any thoughts of wanting to hurt yourself?
History of psychosis that was not related to substance use? YES NO If yes, please share more on a separate sheet.
I authorize the verification of my personal information, treatment/recovery history, and criminal background provided on this form for the purposes of applying to the Full Life Transitional Care Program. I have received a copy of this application.

Signature of applicant:	**Date:**
Signature of staff reviewer:	**Date:**