"CORPORATE ANOINTING" Ministries

1212 W. State St. Fremont, OH 43420
419-333-0773 Office
Email: cambox283@yahoo.com

Phase I Recovery Application

DIRECTIONS: Must be legible, Use Pen only, ALL lines must be filled incompletely (mark through or mark N/A if they do not apply). IF application is received and incomplete your application will be declined.

APPLICATION Application Date: _____

Referred by: _____ Phone: _____

(full name or organization doing the referral)

Name: _____ Phone: _____

First Middle Last

Date of Birth: _____ Birthplace: _____ SS#: _____

Driver's Lic. No. _____ State Issued: _____ Current/*Valid*: Yes ____ No ____

Age: ____ Height: ____ Weight: ____ Eye Color: ____ Hair Color: ____

How did you hear about this Recovery House? _____

Are you presently homeless or at-risk of homelessness? Yes ____ No ____ If yes, reason for homelessness:

() Overcrowded () Shelter () Affordability () Behind in Rent () Domestic Violence

() Eviction () Other _____

Are you currently (Check all that apply):

() Leaving a Residential Treatment Program () Exiting Incarceration

() Receiving Medication Assisted Treatment Services () Being Discharged from a Hospital

() Other _____

Describe current living situation: _____

_____

Explain Reason for Seeking a Recovery Program- Phase I with CAM: _____

_____

Residential Information

Current Address: _____ Phone: _____

Previous Address: _____ Phone: _____

Have you ever been evicted? Yes ____ No ____ If yes please explain when, reason, and location: _____

_____

Do you have any outstanding electric, gas, heating, or cable bills in your name: Yes ____ No ____ If yes please describe?

_____

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Family History

Married ____ Widow ____ Single ____ Separated ____ Divorced ____

Spouses Name: _____ Phone: _____

List names and ages of Minor children: _____

Circle Answers: Father - Living Deceased Disconnected Open Communication

Mother - Living Deceased Disconnected Open Communication

Siblings - Living Deceased Disconnected Open Communication

Criminal Background

Have you ever been convicted of a Felony or have pending charges? Yes ____ No ____ If yes please explain:

_____

Have you ever been convicted of a Misdemeanor charge or have pending charge? Yes ____ No ____ If yes please explain:

_____

Are you currently incarcerated? Yes ____ No ____ Where: _____

Have you been in Prison? Yes ____ No____ Where: _____

State / Federal County Institution

Period of Time Served: _____ Probation Expiration Date: _____

Probation or Parole Officers Name: _____ Phone: _____

County of Jurisdiction: _____ Municipal Court or Criminal (circle one)

Are you a Registered Sex Offender? Yes ____ No ____ Have been involved in Domestic Violence? Yes ____ No ____

Have a CPO or Restraining Order? Yes ____ No ____ Have Been involved or committed Arson? Yes ____ No ____

Do you have a History of violence toward self, others, or property Yes ____ No ____ If yes explain _____

_____

Ado you have Supervisory Fees? Yes ____ No ____ Unknown ____ Amount _____

What is your drug of choice? _____ What is the time you medicate yourself? _____

Circle what you are you in need of: Independent Housing Supportive Housing Halfway Housing Rehab

Detox Counseling Pastoral Counseling General Assistance AA/CA/HA or NA Mentoring

Other _____ 12 Step Program

Have you been in Rehab before? Yes ____ No ____ In-house Treatment or Out-Patient (circle one)

Where? _____ Date: _____ Length of Program? _____

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EDUCATION

Level of Education: High School Diploma ____ College ____ GED ____ Level completed ____

Course Work Completed: _____ Certificate Program Completed: _____

Did you complete programming while incarcerated? Yes ____ No ____ If yes, list completed programming: _____

_____

Military Records

Were you in the Military? Yes ____ No ____ Branch of Service _____ Contact Number: _____

Name of Rep. _____ Do you have your DD214 Paperwork? Yes ___ No ____

Public Assistance Record

Are you currently on Public Assistance? Yes ____ No ____ If yes, what type? WIC ____ Food Stamps ____

Medical _____ Cash Assistance _____

What county did you receive assistance in? _____ Year of Service: _____ Case Number _____

Case Manager: _____ Phone: _____

Do you owe child support? Yes ____ No ____ If yes, amount owed? _____

Work Information

Employer: _____ Job Title: _____ Phone: _____

Address: _____ Supervisor: _____

Schedule: _____

Monthly Income Source

Source:	Amount:	Source:	Amount:
Alimony	_____	SSI/SSD	_____
Child Support	_____	Veteran's Administration	_____
Employment	_____	School Loans	_____
Welfare/ADC/TANF	_____	Any Other Income	_____
Retirement Pension	_____		

Applicants Employment Status (Mark All That Apply)

	How Long in this Position?		How long in this Position?
() Permanent Full-time	_____	() Temporary Full-time	_____
() Permanent Part-time	_____	() Temporary Part-time	_____
() Enrolled in College	_____	() Enrolled in Training Program	_____

Are you employable? Yes, No (circle one) If No why? _____

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Medical Information

Last Physical Examination: _____ Last Hospitalization: _____

Reason for Hospitalization: _____

Are you presently in need of Medication? Yes ____ No ____ If yes, list: _____

_____

List Allergies: _____

List Physical conditions that limit or restrict your activity: _____

Circle all that apply: Asthma Breathing Problems Heart Blood Pressure

Food Allergies Dental Sleep Issues Diabetic Seizure Disorder

List any other medical issues: _____

_____

Describe any other related health conditions or surgeries: _____

Have you been diagnosed with Mental Health issues including depression or anxiety? Yes ____ No ____

Diagnosis: _____ Who Diagnosed it? _____ Date of Diagnosis: _____

Have you ever been Diagnosed with Behavior Issues, Substance Abuse (Alcohol/drugs), Learning Disabilities, or Physical disabilities? Yes ____ No ____ Diagnosis: _____

Who Diagnosed it? _____ Date Diagnosed: _____

What Medication where you prescribed? _____

Have you ever tried to injure yourself or commit suicide? Yes ____ No ____ If yes, when: _____

List current medications prescribed, non-prescribed, and over the counter meds: _____

_____

Supply three (3) references:

Name: _____ Relationship: _____ PH: _____

Name: _____ Relationship: _____ PH: _____

Name: _____ Relationship: _____ PH: _____

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Emergency Contact Information

Substance Use / Abuse / Dependency / Addiction History:

Substance	Age first used	Age/date of last use	Frequency (Times/month)	Daily use history (Yes/No)	Quantity	Method of use
Alcohol						
Marijuana						
Cocaine						
Heroin						
Suboxone						
Methadone						
Methamphetamine						
Ecstasy/ MDMA						
Inhalants						
Hallucinogens (LSD, PCP, acid, psilocybin, peyote, etc.)						
Prescription Medication (Vicodin, OxyContin, Ultram, Xanax, Adderall, Ritalin, Valium, etc.)						
Over-the-counter Medication (DXM/Robitussin, codeine cough syrup, diet pills…)						
Other						

Contact Name: _____ Relationship: _____

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Current Address: _____ Phone: _____ Cell: _____

Street City/ State/Zip

Contact Name: _____ Relationship: _____

Current Address: _____ Phone: _____ Cell: _____

Street City/ State/Zip

Additional Questions

Describe what you have done for your Recovery that has been successful: _____

_____

Describe what you have done that has not been successful: _____

_____

Do you have individuals in your life open to helping you establish Recovery? Yes ____ No ____ Who: _____

_____

Are there people in your life who might be unsupportive of your Recovery Journey? Yes ____ No ____ Who: _____

_____

What is the best way we could support you in establishing Long-term Recovery? _____

_____

Additional Comments

_____

_____

_____

I verify that all the information provided as part of this application is truthful and accurate. I also understand that failure to disclose information could lead to my disqualification for residency or termination of my residency.

_____

Signature of Applicant Date