

## Application for Hope Home Residency

Return to: [hopehome@dlcmhc.com](mailto:hopehome@dlcmhc.com), or  
6075 Bathey Lane, Naples, FL 34116

Resident Candidate Name: \_\_\_\_\_ Id # I (if known): \_\_\_\_\_

Current address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

What is your current history of sobriety (How long have you been sober from each drug)?:

\_\_\_\_\_  
\_\_\_\_\_

Drug(s) of choice:

\_\_\_\_\_  
\_\_\_\_\_

Method of administration (IV, oral, snorting, other method):

\_\_\_\_\_

Date(s) of last use and frequency:

\_\_\_\_\_  
\_\_\_\_\_

History of substance use disorder treatment, explain (how many times in detox, how many treatment episodes other than detox? When was your last treatment episode? Where?):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recovery Supports:

Home group: Yes \_\_\_\_\_ NO: \_\_\_\_\_ Date of last attendance: \_\_\_\_\_

Sponsor: Yes No: \_\_\_\_\_ Date of last contact with sponsor: \_\_\_\_\_

Peer support specialist/recovery coach: Yes: \_\_\_\_\_ No: \_\_\_\_\_

A.A., N.A., C.A., or other social support group: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Date of last meeting: \_\_\_\_\_

Celebrate Recovery: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date of last attendance: \_\_\_\_\_



SMART Recovery: Yes: \_\_\_\_\_ NO: \_\_\_\_\_ Date of last attendance: \_\_\_\_\_

Other (please identify and explain):

\_\_\_\_\_

Recovery/Sobriety plan:

\_\_\_\_\_

\_\_\_\_\_

How do you consider your overall health? : Good \_\_\_\_\_ Fair: \_\_\_\_\_ Poor: \_\_\_\_\_

Current Health condition (s): \_\_\_\_\_

Are you able to self-care: yes: \_\_\_\_\_ No: \_\_\_\_\_ If no, please explain:

\_\_\_\_\_

Please list current medications-include over-the-counter medications (please explain the purpose for each medication) (use back of paper if more room is needed):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have a primary care physician? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Have you had any recent thoughts of harming yourself or others? Yes: \_\_\_\_\_ NO: \_\_\_\_\_

Do you have past history of self-harm or harming others? If so explain: Yes: \_\_\_\_\_ No: \_\_\_\_\_

\_\_\_\_\_

History of violence: yes (explain each incident, provide month /year): Yes: \_\_\_\_\_ No : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Married/significant other/divorced/separated? \_\_\_\_\_

Children Yes: \_\_\_\_\_ No: \_\_\_\_\_ (living situation)

\_\_\_\_\_

Current living situation: \_\_\_\_\_

Are you currently employed?: Yes: \_\_\_\_\_ NO: \_\_\_\_\_

Are you currently participating in a Medication Assisted Therapy Program: Yes \_\_\_\_\_ NO \_\_\_\_\_

If yes be explain, location, medication and current dosage:

\_\_\_\_\_

\_\_\_\_\_

MAT Physician: \_\_\_\_\_

Are you in need of detoxification services: Yes: \_\_\_\_\_ No: \_\_\_\_\_