House of Hope Recovery House / Family Life Counseling and Psychiatric Services
151 Marion Ave., Mansfield, Ohio 44907 Phone: 419-774-9969, Fax 419-756-5642

House of Hope is a Level 2 sober living residence in Willard, Ohio. Our mission is to help men who are in recovery from drug and alcohol abuse become productive members of their community by providing transitional housing and support.

House of Hope is designed for male participants with a minimum of thirty days demonstrated sobriety who are committed to sober living with like-minded persons. Huron County residents are preferred, residents from other counties will be considered on a space available basis. The house has a capacity for five participants including a Senior Resident lives in and oversees the house. The term of residence is thirty days and automatically renews unless notification of termination is given. Maximum length of stay at House of Hope is one year. Length of stay may be extended upon request to and approval by the advisory board.

House of Hope is operated by the Starting Point Outreach Center, Inc., 117 Myrtle Avenue, Willard, Ohio; an Ohio corporation for non-profit. Starting Point has existed in the community since 2010, providing support to persons and families in times of crisis. Starting Point is a faith-based organization that enjoys strong relationships with Willard businesses, churches, government and law enforcement.

For persons who are exiting a thirty-day rehabilitation program the recommended timing is as follows:

1. **Complete and submit application, HIPAA release, Requirements-Rules-Rights document by day seven. Ensure the applicant has a valid driver's license or state ID for background check. Make arrangements for financial support.**
2. **House of Hope will schedule a preliminary interview by day fourteen.**
3. **House of Hope will conduct a formal interview by day twenty-one. A face-to-face interview at the rehabilitation facility is preferred.**
4. **If accepted, transport to House of Hope on day thirty.**

The application, HIPAA form, and Requirements, Rules and Rights for participation, as well as additional contact information, can be found online at
http://www.startingpointoc.org/house-of-hope.html

Please direct inquiries to:

Donald Peeler, Executive Director, Starting Point Outreach Center
Email: dpeeler@startingpointoc.org

Michael Bell, House of Hope Project Manager
Email: mbell@startingpointoc.org

Phone: 419-933-4100

Applicant Information and Personal History:

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Full Name: _____ Date: _____

DOB: _____

Current Address: _____

What type of housing is this? _____

Previous Address: _____

Telephone Numbers: _____ (h) _____ (c)

What is your sobriety date and how can it be verified? _____

_____

Provide contact information for the person(s) you authorize us to contact in the event of a medical emergency or if you are terminated from program participation. I also authorize mail to be sent to this address for fourteen days following my departure from House of Hope. After fourteen days mail will be returned to sender.

Name _____ Phone _____ Relationship _____

Address _____ City/State/ZIP _____

Name, address and phone of your caseworker/counselor: _____

_____

Valid Driver's License or State ID: ☐ Yes ☐ No DL/ID Number: _____

Your highest level of education: _____

Are you a registered sex offender? ☐ Yes ☐ No

Have you ever been charged with or convicted of a sex offense? ☐ Yes ☐ No

Have you ever been charged with or convicted of arson? ☐ Yes ☐ No

Please Check any/all of the following that apply to you:

☐ Pending Court Case: _____
☐ On Probation
☐ On Post Release Control (Parole)
☐ Have a Criminal History. If checked, please list all offenses and dispositions:

_____

_____

_____

_____

State and Counties of charges/convictions: _____

Name and telephone number of probation officer: _____

_____

Have you ever served in the military? ☐ Yes ☐ No

Do you have a significant other? ☐ Yes ☐ No

Please provide their name and contact information: _____

_____

Please provide the names and ages of any children that you have, and indicate if you have custody of those children:

Name: _____ Age: _____ Custody: ☐ Yes ☐ No

Name: _____ Age: _____ Custody: ☐ Yes ☐ No

Name: _____ Age: _____ Custody: ☐ Yes ☐ No

Name: _____ Age: _____ Custody: ☐ Yes ☐ No

Name: _____ Age: _____ Custody: ☐ Yes ☐ No

Do you owe or pay child support? ☐ Yes ☐ No Total/Monthly Amount: _____

Employment and Financial Information:

Are you employed? ☐ Yes ☐ No Attending school? ☐ Yes ☐ No

If yes, please list the name, address, and phone number of your employer or school:

_____

_____

☐ Full-time ☐ Part-time Position: _____ Rate of Pay: _____

Supervisor's Name and Phone Number: _____

_____

If not employed, list date and place of last employment._____

_____

If you and/or your household are receiving any of the benefits listed below, please check all that apply, and list the monthly amount received:

Disability:	☐ Yes ☐ No	Amount: $_____
Food Stamps:	☐ Yes ☐ No	Amount: $_____
ADC:	☐ Yes ☐ No	Amount: $_____
Unemployment:	☐ Yes ☐ No	Amount: $_____

Do you have insurance?	☐ Yes	☐ No
Medicare?	☐ Yes	☐ No
Medicaid?	☐ Yes	☐ No

Insurance Provider: _____

Are you able to pay the participation fee and purchase your own food for House of Hope participation? ☐ Yes ☐ No

Do you agree to attend weekly 12 Step Meetings? ☐ Yes ☐ No

Do you agree to participate in activities that take place in the home (such as house meetings and other support and learning opportunities)? ☐ Yes ☐ No

Do you agree to contribute to the care of the household (such as doing chores, taking care of the house and lawn, cooking, and cleaning up after yourself)? ☐ Yes ☐ No

What date do you expect to be available for participation? _____

What goals would you like to achieve in the next year?

_____

_____

_____

What are your expectations of the *House of Hope* Recovery Program?

_____

_____

How did you learn about House of Hope?

_____

Please provide any other information that should be known about you or your situation.

_____

_____

I, _____ (Applicant Printed Name), declare that all of the foregoing statements of information are true and correct. I acknowledge that falsification of information may result in not being accepted into or dismissed from House of Hope participation. I authorize the release of this information sufficient to obtain a background check and other means necessary to verify all or part of the information I have provided. I authorize contacting the above mentioned person(s) in the event of a medical emergency or termination from participation.

_____ _____

Applicant Signature Date