



1747 N. Wells St
Fort Wayne, Indiana 46808
260.420.6100
260.407.1511 (fax)

RESIDENTIAL PROGRAM APPLICATION

Applicant Name: _____

Doc #: _____

Applicant Phone Number: _____

Application Date: _____

Hope Alive does not discriminate on the basis of race, ethnicity, color, sex, gender, sexual orientation, religion, creed, national origin, age, or disabilities in the admission of women into our residential program. However, due to the nature of a transitional living program, with the goal of aiding women to become self-sufficient, residents must be physically and emotionally able to do all household and yard chores. If at some point a resident becomes unable or unwilling to do these chores, she will be required to leave this program.

For Office Use Only Date Application Received _____

Notes: _____

Move-In Date: _____

Please initial when completed:

_____ First interview _____ Case Management

_____ Second interview _____ Counselor Assigned

_____ Drug screen _____ Rental Agreement

_____ Intake

Residential Program Application

(Please print)

Name: _____ Birthdate: _____ Age: _____

Current Address: _____ City: _____ Zip: _____

Are you coming from another shelter? Yes / No Are you coming from a correctional facility? Yes / No

If YES to either, please name shelter/facility: _____

Expected release/discharge date: _____ Phone: _____ Alternate Phone: _____

May we leave messages at either number? Yes voicemail ___ Yes other person ___ Yes text message ___ No messages ___

**By checking "Yes text message", I agree to get text messages from Hope Alive regarding my application, program, and/or services. Consent is not a condition of receiving services. Message & data rates may apply; frequency varies. Reply STOP to opt out or HELP for help. View our terms (hopealivefortwayne.org/terms) and privacy policy (hopealivefortwayne.org/privac).

Email Address: _____

Referred to Hope Alive By: _____

Family

Though Hope Alive does not allow children to live in our apartments, we want to understand your family.

How many children do you have? _____ What are their ages? _____

Are you currently working to reunify with your children? Y / N Are you currently involved with DCS? Y / N

If involved with DCS, please name your caseworker: _____

Caseworker phone: _____ **Please note, we will require a release to coordinate with caseworker.

Do you have children under the age of 18 who may be visiting you at Hope Alive? Yes No

If YES, please list an emergency contact for your children:

Emergency Contact: _____
(NAME) (RELATIONSHIP) (PHONE NO.)

Please describe your reason for applying to Hope Alive: _____

What would you like to accomplish while living at Hope Alive?

Race/Ethnic Background

What is your race/ethnicity?

White Hispanic/Latino
 Asian American American Indian/Alaskan Native
 Black/African American Multiracial (please specify) _____
 Native Hawaiian/Pacific Islander International (please specify) _____

Is your primary language something other than English? Yes / No If YES, name primary language: _____

Education & Occupation Information

Please indicate your educational level:

Less than high school Some College (no degree completed)
 H.S. equivalent/GED Bachelor's Degree
 High School Diploma Master's Degree
 Vocational Doctoral Degree Other

Are you currently in school? Yes No If yes, where: _____

Are you currently employed? Yes No

If YES, who is your current employer? _____

Date this employment began: _____ Is this job through a temp agency? Yes / No

Hours worked per week: _____

If NOT employed, what is your income source? _____ Monthly Amount: _____

If NOT employed, how long have you been unemployed? _____

Housing History

Have you ever been evicted? Yes / No If yes, for what reason? _____

Have you ever received government assistance for housing? Yes / No

If you are currently living in a shelter, please provide the name and phone number of your case worker:

Case worker Name: _____ Phone: _____

**Please note, we will require a release to coordinate with your caseworker.

Please list your last 2 residences, other than your current address, starting with the most recent:

1. Address: _____ Dates (start-end): _____

Reason for leaving: _____

2. Address: _____ Dates (start-end): _____

Reason for leaving: _____

Legal Background (CHECK AS MANY AS APPLY):

No legal history Arrest(s) non-substance related Arrest(s) substance related
 Currently on probation Currently on parole Court ordered treatment Jail/prison time served
 Drug Court Currently on home detention

Probation / Parole officer name: _____ Phone: _____

**Please note, we will require a release to coordinate with your probation/parole officer.

Have you been arrested in the past year? Yes No If yes, how many times? _____
In the past year, have you spent any time in jail? Yes No If yes, how many nights? _____

Please describe the most recent legal issue:

List and describe any conviction(s), date of conviction(s), and any pending charges:

In the past year, were you a victim of any violent crimes such as assault, rape, or domestic violence?
 Yes No

Physical Health History

How would you rate your overall health at present? poor fair good excellent

Are you disabled? Yes No If YES, please describe: _____

Please list any medications you are currently taking and the condition they treat:

Mental Health History

Have you ever received treatment for, or been diagnosed with, a mental illness? Yes No

If YES, please describe:

Have you ever been hospitalized for a mental health related issue? Yes No

Are you *currently* receiving counseling or other mental health treatment from another organization? Yes / No

If YES, please provide the name of your therapist/care provider: _____

Counselor/Care Provider Phone Number: _____

**Please note, we will require a release to coordinate with your current counselor/care provider.

Do you have a history of substance or alcohol abuse? ___Yes ___No

Please describe: _____

Do you currently drink alcohol? ___Yes ___No

Do you currently use drugs/pills? ___Yes ___No

When was the last time you used an illegal substance, misused prescription drugs, or drank alcohol?

*I understand that I am applying for a **program** designed to aid women in becoming healthy and self-sufficient in mind and body. I understand this program will require me to:*

- Pay rent monthly in accordance with my lease.
- Provide my own food, household supplies, and transportation.
- Comply with all Resident Expectations.
- Participate in program services as required.
- Assist with household and yard chores.

I understand that if, at any point, I become unable or unwilling to meet these requirements, I will be required to leave this program and vacate my apartment.

I understand that if, at any time, Hope Alive staff believe my needs exceed those which they are equipped to serve, or Hope Alive staff determine that my needs are outside of their scope of practice, Hope Alive will provide me with appropriate referrals for alternative resources and care providers and discharge me from the Residential Program. I understand that if this happens, I will be required to leave the program and vacate my apartment.

I acknowledge that I am:

- *Physically, mentally, and emotionally capable of living in a community environment without significant staff assistance.*
- *Physically, mentally, and emotionally capable of doing all household and yard chores.*
- *Willing to partner with Hope Alive staff to meet my individual goals.*

I understand that I am going to be given a drug and alcohol screening prior to being admitted to Hope Alive's Residential Program. I also certify that the above information is true and accurate to the best of my knowledge. I understand that falsified information may be cause for my dismissal from Hope Alive's program.

Signature _____ Date _____

Printed Name _____

Hope Alive Resident Expectations

All residents of Hope Alive's Transitional Housing Program are expected to comply with the following expectations. Failure to do so may result in being required to leave the program. If you do not understand an expectation or wish to understand the rationale behind it, feel free to ask staff to explain.

CONDUCT

- Absolutely no drug, alcohol or prescription narcotics (even if prescribed by your physician) are allowed on premises – you MUST provide a NEGATIVE urine/breathalyzer at any time.
- Absolutely no weapons of any kind are allowed on the premises.
- Violence or threats of violence will not be tolerated.
- Be respectful and courteous to each other, staff, and neighbors.
- Stealing will not be tolerated.

MAINTENANCE

- Part of transitional housing is learning responsible property maintenance and upkeep, including yard work, snow removal, leaf removal, and overall upkeep of the yard. Therefore, ALL RESIDENTS are required to share in the responsibility of these tasks. Yard work will be assigned on a rotating basis, and all residents will be expected to take turns with each task, including mowing.
- Residents are expected to keep their rooms and common areas clean, including taking part in dish washing, trash removal, and other household chores.

PERSONAL PROPERTY

- ALL personal property must be kept in an orderly fashion. Make sure you comply with space and storage rules (no moving furniture in or out etc.).
- All rooms, your person, and your vehicle are subject to inspection at any time.
- Upon check-out, all personal property must be taken with you. Anything left behind will be discarded.
- No personal furniture is allowed to be brought into the apartment or personal rooms at any time. Small flat-screen TVs are allowed.

GENERAL

- To maintain cleanliness of Hope Alive, when moving in, all personal items will be placed in a “bug zapper.”
- Residents are expected to pay rent for their room and utilities. (Program is included at no extra cost.) Failure to do so will result in eviction. Rent is due by the 3rd of each month. All accrued rent charges are required to be paid, including any remaining balance, upon exit from Hope Alive.
- Residents must supply their own food, toiletries, paper products (including toilet paper, paper towels, etc.), cleaning supplies, laundry products, etc. If you need help with this, please see the office.
- Residents must attend 2 groups, case management, and counseling weekly and must be on time.
- Supervised urine drug screens and breathalyzers will be administered upon interview, at admission, and at random throughout your stay at Hope Alive. Any positive drug screen will result in an immediate dismissal.
- No smoking or using tobacco products (including vaping and e-cigarettes) is allowed in the apartments.
*****Effective August 1, 2024 – Hope Alive will be a completely Tobacco-Free Campus. Smoking, vaping, and any tobacco use, including all related products, will be prohibited on all Hope Alive property. *****
- To spend a night away from Hope Alive, residents must have been at Hope Alive at least 2 weeks, be working at least 15 hours, and request approval via Overnight Pass Request. Please note residents on a problem-solving court (drug court, mental health court, hope probation, etc.) must gain approval through the court first.
- Residents that are not working at least 15 hours per week are required to participate in work study at Hope Alive.
- Residents are expected to take medication as prescribed.

- Pets are prohibited.
- Curfew hours are Sunday-Thursday at 11pm and Friday and Saturday at 12am during months May 1st-Oct 1st and Oct. 1st-May 1st curfew is Sun-Thurs 10 pm Friday & Saturday 11pm.
- Quiet time is 9:30pm-7:30am. Visitors, including residents from other apartments, are not permitted during this time.
- Anyone choosing not to fulfill their program responsibilities at Hope Alive, or not complying with these expectations will be asked to leave Hope Alive.

By signing below, I, a potential or admitted resident of Hope Alive, acknowledge that I have read and understood all the above expectations and am willing, able, and agree to abide by them. I understand that failure to abide by these expectations may result in my being asked to leave Hope Alive.

Signature: _____ Date: _____

Printed Name: _____

RESIDENT EMERGENCY CONTACT FORM

This form will be given to emergency medical personnel to help in your care – please provide all pertinent information.

Resident's Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Primary Physician Name _____

Address: _____ Phone: _____

Allergies: _____

Current Medical Conditions: _____

Current Medications: _____

Past Hospitalization(s)/Reason: _____

Emergency Contact Information

Emergency Contact Name: _____

Relationship: _____

Phone Numbers: _____
(Cell) (Home) (Work)

Emergency Contact Name: _____

Relationship: _____

Phone Numbers: _____
(Cell) (Home) (Work)

Next of Kin: _____

(Cell) (Home) (Work)

I give Hope Alive personnel permission to disclose any information to my emergency contact(s) listed above that they feel is necessary to obtain the emergency care I need.

Signature _____ Date: _____

***** If your circumstances are such that we will need to coordinate your application, move-in, and/or ongoing care with a third party (such as a lawyer, case manager, family member, justice system, etc.), we will need your consent to do so. *****

Information Disclosure Authorization

To allow Hope Alive staff to verbally share protected health information to designated parties according to your wishes, please complete to following Information Disclosure Authorization form.

The purpose of this disclosure is (check all that apply):

- To coordinate my application and potential admission to Hope Alive.
- To coordinate ongoing care and services provided by Hope Alive (after admission) with others.
- Other: _____

List below specific individuals with whom your protected health information can be verbally shared for the purposes noted above.

Name of person(s) authorized to receive information	Relationship to You	Phone Number

*I understand that I have a right to revoke this authorization in writing at any time and that a revocation will have no effect on action already taken in reliance of this authorization.

*I understand that treatment, payment, enrollment, or eligibility is not conditioned by my signing this authorization.

Client Signature: _____ Date: _____

Client's Printed Name: _____