

Adira Sober Living for Women

603-581-8090

adirasoberliving@gmail.com

APPLICATION

Please return by email to adirasoberliving@gmail.com

If you were referred to our home by a counselor or other professional, please check that you have signed a release of information authorization with that professional, allowing them to speak with us.

Name: _____ Date: _____

Phone: _____ Date of birth: _____

Address: _____

Emergency contact and phone: _____

Next of kin, if not emergency contact: _____

Relationship: _____ Phone: _____

How did you hear about Adira Sober Living? _____

HISTORY

Were you recently asked to leave a sober house or treatment center? _____

If so, what was the reason? _____

Have you ever been evicted? _____ if so, why? _____

When did you last use illegal drugs or alcohol? _____

Do you have any outstanding warrants, pending criminal charges or upcoming court dates? _____

Are you on probation, parole, or suspended sentence? _____

Have you ever been convicted of or do you face pending charges for any act associated with the death or disability of a law enforcement officer? _____

Have you ever been convicted of or do you face pending charges for a hate crime? _____

Are you a convicted sex offender and/or required to register as a sex offender in any state? _____

Do you have a history of violence? _____ if so, explain: _____

Are you currently subject to an order of protection (restraining order) by the court? _____

If so, please explain: _____

PLEASE COMPLETE IF YOU ARE CURRENTLY ENROLLED IN A TREATMENT PROGRAM OR DOC FACILITY

Treatment program or DOC facility: _____

Date you arrived at or were admitted to program/facility: _____

Discharge/release date: _____

Aftercare coordinator or DOC supervisor: _____

Contact information: email: _____

phone with ext: _____

MEDICAL

Are you undergoing medication assisted treatment (MAT/MAR) such as methadone or suboxone? _____

If you have answered yes, please pay special attention to the last section of this application.

Please list any physician-prescribed medications: _____

Do you have a history of seizures? _____

Do you have known allergies to: Medications: _____

Food _____ Animals _____

Latex _____ Seasonal _____ Other _____

Do you use a rescue inhaler or Epipen? _____

Other than alcoholism and/or addiction, do you have any medical conditions or physical disabilities that Adira should be aware of? _____

Other than alcoholism and/or addiction, do you have any mental health issues or disabilities that Adira should be aware of? _____

Do you have medical insurance (in case of medical emergency): _____

Policy name/number: _____

GENERAL QUESTIONS

Marital status: _____ Children: _____

Please tell us about your current employment (where/hours/supervisor, etc.): _____

Do you have a valid driver's license? _____ Will you need parking? _____

If so, license number and state: _____

Make/model/license number of vehicle: _____

What is the biggest challenge you face in sustaining your recovery? _____

How do you hope being a part of Adira will help with your recovery? _____

What personal qualities will you contribute to the mutual support we share in our home? _____

Is there any reason you might have trouble following our home's guidelines and expectations? _____

If yes, explain: _____

Do you have problems getting along with others? _____

temper ___ social awkwardness ___ anxiety ___ arrogance ___ bullying ___ sarcasm ___

control issues ___ shyness ___ lying ___ defiance ___ not fitting in ___ racism or bigotry _____

Other: _____

Our home is dedicated to the spiritual practice of the 12 steps. What reservations/reluctance do you have about 12 step spiritual practice? _____

Is there anything else you think we should know about you? _____

If You Are Undergoing Medication Assisted Treatment or Recovery (MAT/MAR) Please Complete the Following Section

Type of MAT: _____ Dosage: _____
Form (injection, wafer, strip, tablet, liquid, etc.) _____
How many times a day? _____ Time(s) of day: _____
Clinic name and location: _____
Prescriber: _____

Does your prescriber provide regular medical monitoring for blood pressure, etc? _____

Does your prescriber require regular counseling or group sessions while you are prescribed MAT? _____

If your MAT is dispensed daily by a clinic or if your prescriber requires regular attendance at groups or counseling, do you have a plan for transportation to and from the dispensary, counseling, or pharmacy? _____

If so, what is that transportation plan? _____

When did you begin MAT? _____

What are your long terms goals concerning MAT? _____

If you have ever missed a dose of your MAT, how did you react, physically and emotionally?

Do you have a tapering plan? _____ if so, what is that plan? _____

Does your provider/prescriber support your taper plan? _____

Does your provider/prescriber offer supports to mitigate withdrawal symptoms if you were to taper off your MAT? _____

If so, what type of supports: _____

Do you feel MAT would prevent you from full participation in a 12 Step program? _____

Is there additional information you would like to add: _____

AGREEMENT

Monthly fee is \$ _____. First month's fee is due upon arrival after signing agreement.

I certify that all information provided in this application is true.

Signature: _____ Date: _____

Adira Sober Living

Financial Agreement

This document outlines the financial expectations for residents of Adira Sober Living. The undersigned resident agrees to the following:

An intake fee of \$400 is due upon arrival at Adira. This payment is not credited towards the weekly program charge. If this intake fee cannot be paid in full upon arrival, a payment arrangement must be approved by a Director prior to moving into the home.

Intake fee payment: \$ _____ received on _____

If not paid, what funding has the resident sought:

In addition to the intake fee, the undersigned resident further acknowledges that they are expected to pay a \$200 weekly housing fee every Friday. (Residents who first move in on a Saturday, Sunday, Monday, or Tuesday will pay their first weekly housing fee on the upcoming Friday. Residents who first move in on a Wednesday, Thursday, or Friday will pay their first weekly housing fee on the Friday of the following week.)

By signing below, the resident acknowledges the above and agrees to comply with all requirements written in this financial agreement. Failure to comply with these requirements, or failure to obtain funding, may result in discharge from the program.

Resident Name (Print): _____

Resident Signature: _____

Date: _____

Adira Representative (Print): _____

Representative Signature: _____

Date: _____