**Hope House Augusta Application**

1. Please note, the following survey collects sensitive data and PII (Personally Identifiable Information).

* I have read the above and consent to Hope House Augusta collecting sensitive and PII data about me.

1. Please provide your full name, (i.e. first, middle initial and last name)
2. Preferred Name, i.e., what do you prefer to be called?
3. Do you identify as male?

* Yes (Please try another facility, Hope House is a Women’s Treatment Facility)
* No

1. What is your current telephone/contact number? If you are currently residing within a facility (jail, prison, hospital, detox unit), please indicate a contact person/case manager that we may contact. If you are incarcerated, what is your release date, court date, or sentencing date?
2. Please enter an additional contact number (for a family member, case manager, community supervision officer, etc.) you would like to list.
3. Were you referred to treatment at Hope House?

* Yes
* No

1. Who or what agency referred you to Hope House?

* Community Supervision (Probation or Parole)
* Georgia Department of Family & Children Services (DFCS)
* Augusta Judicial Circuit Drug Court
* Serenity Behavioral Health Systems
* Georgia Regents Health System (GRU)
* Georgia Behavioral Health Link
* Other

1. What is your date of birth?
2. Why are you seeking treatment and/or housing at Hope House? What are the circumstances that lead to your referral? (i.e., "I am an unsheltered resident" or "I have been sentenced to treatment" may be appropriate responses)
3. Were you or a member of your household evicted from federally assisted housing for drug related criminal activity within the last three years?

* Yes
* No

**12**. Were you or a member of your household ever convicted of drug related criminal activity for the manufacture or production of methamphetamine on the premises of federally assisted housing?

* Yes
* No

1. Are you or a member of your household subject to a lifetime sex offender registration requirement in Georgia or in other states where you are known to have resided?

* Yes
* No

1. Do you have medical insurance?

* Yes
* No

1. What company do you have medical insurance with? What is your policy and group number? If you do not have insurance, type N/A for not applicable.
2. Have you ever served in the military?

* Yes
* No

1. Has an immediate family member (mother, father, son, daughter, brother, sister) served in the military?

* Yes
* No

1. What is your race/ethnicity? \*

* Hispanic
* American Indian or Alaska Native
* Asian
* Black or African American
* Native Hawaiian or Pacific Islander
* White
* Other

1. How do you identify? \*

* Female
* Male
* Transgender
* Gender Variant/Non-Conforming

1. How do you identify? (Sexual Orientation)

1. What is your living situation?

* Homeless
* Staying with friends
* My permanent address is

1. Are you a Georgia resident? (Hope House can only serve GA residents) \*

* Yes
* No

1. Where was your last known address in the Central Savannah River Area in the state of Georgia?

* Augusta-Richmond
* Burke (Waynesboro)
* Columbia (Evans, Martinez, Harlem, Grovetown, Appling)
* Emanuel
* Glascock
* Jefferson (Wrens, Louisville)
* Lincoln (Lincolnton)
* Screven
* Taliaferro
* Warren
* Wilkes

1. Please re-enter your last known zip code.
2. Do (or did) you lease or own the above address?

* Lease
* Own
* Neither

1. Who were you living/residing with?

* Spouse
* Domestic Partner
* Friend
* Parent
* Lacked Permanent Housing
* Other

1. What is your driver's license number? If you do not have a current license, please enter 'No License.'
2. Are you:

* Single
* Married
* Divorced
* Widowed
* Domestic Partner
* Separated

1. Are you pregnant?

* Yes
* No

1. How many months have you been pregnant?

* 1-3 Months
* 4-6 Months
* 6 or More

1. Are you receiving prenatal care?

* Yes
* No

1. Do you have any children?

* Yes
* No

1. Please list the gender and age of each child:
2. Do you have an active Child Protective Services case with the Georgia Department of Family and Children Services?

* Yes
* No

1. Which county did the case originate?

* Augusta-Richmond
* Columbia County
* Burke County
* McDuffie County
* Jefferson County
* Lincoln County
* Other

1. Please list the name and contact number for your DFCS case worker/manager.
2. Do you have custody of your children?

* Yes
* No

1. What are your child care plans?

* Have child(ren) live on site
* Family member has temporary custody
* Child is no longer a minor
* Foster care
* Other

1. Are you seeking reunification with your children?

* Yes
* Not Applicable
* No

1. Are you currently employed?

* Yes
* No

1. If yes then where?
2. Do you currently have any form of income? (i.e. Social Security Income, Temporary Assistance for Needy Families (TANF), Child Support, etc.)

* Yes
* No

1. Please select your source of income from the following:

* Temporary Assistance for Needy Families (TANF)
* Supplemental Nutrition Assistance Program (SNAP) - Food Stamps
* Medicaid
* Medicare
* Social Security Income (SSI)
* Social Security Disability Income (SSDI)
* Unemployment Income
* Child Support
* Other

1. Please identify the amount of income. If you selected 'Other,' please identify the source of income.
2. What was the first age you used alcohol or other drugs?

* Under 13
* 13-15 years old
* 16-18 years old
* 18-20 years old
* Over 21 years old

1. What drug(s) do you use?

* Alcohol
* Methamphetamine
* Heroin
* Prescription Medication/Pills
* Marijuana
* Cocaine
* Kratom
* Other

1. What method(s) have you used to take your drug(s) of choice?

* Drinking
* Smoking (pipe, etc.)
* Swallow (as pill)
* Snort
* Injecton/Shoot Up (Intravenous Use - IV)
* Inhale/Huff
* Oral Ingestion (except swallowing)

1. What was your last date of use and how much?
2. Do you require detoxification/hospitalization?

* Yes
* No

1. Have you ever been in treatment before?

* Yes
* No

1. How many times have you been in treatment?
2. When and where did you receive treatment?
3. Did you ever leave treatment against medical advice (AMA)?

* Yes
* No

1. Do you currently have any medical conditions or problems?

* Yes
* No

If yes please describe.

1. Please list any and all medications you are currently taking.
2. Are you currently prescribed any of the following medications?

* Suboxone
* Methadone
* Subutex
* Buprenorphine
* Naltrexone
* Vivitrol
* None of the Above

1. Have you ever been on Medically Assisted Treatment (MATS)? Are you interested in using MATS?

* Yes
* No
* I don't know

1. Who is your current physician/doctor? If you do not currently have or are seeing a doctor, please list N/A.
2. What is your height and weight?
3. Please list any and all allergies you may have, including food(s), bug(s), etc.
4. Are you currently incarcerated?

* Yes
* No

1. Are you now or have you ever been affiliated with organized crime?

* Yes
* No

1. Do you currently need medical attention?

* Yes
* No

1. Please describe your current medical need(s). (i.e., if you are diabetic and in need of insulin, etc.)
2. Have you had a tuberculosis (TB) or PPD test in the last six (6) months?

* Yes
* No

1. What were the results?

* Positive
* Negative

1. Do you have any mental and/or physical disabilities?

* Yes
* No

1. Please specify.
2. Do you currently have any pending or past legal problems?

* Yes
* No

1. Please describe the charge, date, and sentence. (i.e. arrested in June 2015 for drug possession in Columbia County, currently participating in drug court services, etc.)
2. Are you currently under community supervision, i.e. probation or parole in any county, state, or with a federal office?

* Yes
* No

1. Please list the contact information for your community supervision officer (name, phone number, address, etc.)
2. Does your community supervision officer know that you are seeking treatment at Hope House, Inc?

* Yes
* No

1. How often are you required to report for community supervision?
2. For compliance and to protect your privacy please expect a phone call from Hope House (706-737-9879) to share your social security number. Please note: an application cannot be processed without a social security number.

* I understand
* I do not understand

Signature:

1. I hereby declare that all the information I have given in this application (survey) is true. I understand that any false information will be grounds for non-admission to or dismissal from the Hope House, Inc. program. I also understand that submitting this application does NOT guarantee entrance into the Hope House, Inc. residential or intensive outpatient treatment program.

* Agree
* Do Not Agree

Initials: