DOVE
RECOVERY HOUSE FOR WOMEN

Resident Application

Please complete this application to the best of your ability. All information is confidential and will be reviewed by staff regarding program eligibility. Dove House staff will review your information and contact you regarding next steps.

Date of Application: _____

Preferred Location (check one):

- ☐ Marion County
- ☐ Dubois County

Demographic Information

Full Legal Name: _____

Any Prior Names Used: _____

Preferred Name (if different): _____

Date of Birth: _____ **Age:** _____

Social Security Number: _____

Current Mailing Address:

_____

City: _____ **State:** _____ **ZIP Code:** _____

County of Residence: _____

Phone Number: _____

Email Address: _____

Where are you currently living? (check one):

- ☐ Own home/apartment
- ☐ Renting
- ☐ Staying with Friends/Family (couch surfing)
- ☐ Emergency Shelter
- ☐ Transitional Housing
- ☐ Living in a Car/Abandoned Building
- ☐ Jail/Prison
- ☐ Residential Treatment Program
- ☐ Hospital/Medical Facility
- ☐ Other: _____

Gender Identity (check one):

- ☐ Female
- ☐ Transgender Female
- ☐ Other: _____

Preferred Pronouns:

- ☐ she/her/hers
- ☐ they/them/theirs
- ☐ Prefer not to answer

Sexual Orientation:

- ☐ Heterosexual / Straight
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Other: _____
- ☐ Prefer not to answer

Race (check all that apply):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ 2 or more races or Mixed
- ☐ White or Caucasian
- ☐ Other: _____
- ☐ Prefer not to answer

Ethnicity (check one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Marital Status:

- ☐ Single
- ☐ Married divorced
- ☐ Separated
- ☐ Widowed

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Email Address: _____

Referral Source

Who referred you to Dove House? _____

_____

Referral Contact Info (if known): _____

_____

Household Information

Household Size (who you live with including yourself): _____

Estimated Household Income Yearly (select one):

- ☐ $0-$9,999
- ☐ $10,000-$14,999
- ☐ $15,000-$19,999
- ☐ $20,000-34,999
- ☐ $35,000-49,999
- ☐ $50,000-74,999
- ☐ $75,000-99,999
- ☐ $100,000-199,999
- ☐ $200,000 or more

Do you have children?

- ☐ Yes
- ☐ No

If yes, How many? _____

Do you have legal custody of your child(ren)?

- ☐ Yes
- ☐ No
- ☐ Shared

Please list each child's information:

Child's Name (optional)	**Age**	**Gender**	**Currently Staying With** (e.g., you, other parent, foster family, etc.)

Do you currently have an open DCS case?

- ☐ Yes (If yes, provide information below)
- ☐ No

County of Case: _____

DCS Case Manager's Name: _____

Phone Number: _____

Email Address: _____

Do you have childcare arranged during treatment?

- ☐ Yes
- ☐ No

Substance Use History

Substances Used (check all that apply):

- ☐ Alcohol
- ☐ Marijuana / THC
- ☐ Cocaine
- ☐ Crack Cocaine
- ☐ Methamphetamine
- ☐ Heroin
- ☐ Fentanyl
- ☐ Prescription Opioids (e.g., Oxycodone, Hydrocodone)
- ☐ Benzodiazepines (e.g., Xanax, Klonopin, Ativan)
- ☐ Stimulants (e.g., Adderall, Ritalin)
- ☐ Hallucinogens (e.g., LSD, Mushrooms)
- ☐ Inhalants (e.g., aerosol sprays, paint, glue)
- ☐ MDMA / Ecstasy / Molly
- ☐ Synthetic Drugs (e.g., Spice, K2, Bath Salts)
- ☐ Other: _____

Route(s) of Use (check all that apply):

- ☐ Oral
- ☐ Smoking
- ☐ Snorting
- ☐ Injecting (using needle)
- ☐ Other: _____

Have you ever used a needle to inject drugs?

- ☐ Yes
- ☐ No

Have you ever shared needles or injection equipment?

- ☐ Yes
- ☐ No

Age of First Use: _____

Are you currently using substances?

- ☐ Yes
- ☐ No

Date of Last Use: _____

Frequency of current use (e.g., daily, weekly): _____

Have you ever overdosed?

- ☐ Yes
- ☐ No

If yes:

How many times? _____

Date of Most Recent Overdose: _____

What is the longest period you've maintained your recovery? _____

When was that period? _____

Previous Treatment History

Have you ever received treatment for substance use?

- ☐ Yes
- ☐ No

If yes, please complete the table below (add rows as needed):

Date (Approx)	**Program Name**	**Type of Program** (detox, inpatient, residential, outpatient, etc.)	**Length of Treatment**	**Outcome (Completed, Left AMA, etc.)**

Are you currently in a treatment program or facility?

- ☐ Yes
- ☐ No

If yes:

Facility Name: _____

Type of Program (inpatient, residential, withdrawal management, etc.): _____

Projected Discharge Date: _____

Insurance & Public Assistance

Do you have medical insurance?

- ☐ Yes
- ☐ No

If yes: **Type of Insurance (check one):**

- ☐ Medicaid
- ☐ Medicare
- ☐ Private/Employer
- ☐ Marketplace/ACA (HIP)
- ☐ Other: _____

Insurance Provider Name: _____

Policy Number/Member ID: _____

Group Number (if applicable): _____

Primary Insured (if not you): _____

Insurance Phone Number (on card): _____

Are you currently receiving public assistance?

- ☐ Yes
- ☐ No

If yes, *check all that apply:*

☐ SNAP (Food Stamps) ☐ TANF ☐ SSI/SSDI ☐ Medicaid
☐ Housing Assistance ☐ WIC ☐ Other: _____

Employment & Education History

Highest level of education completed (check one):

- ☐ Less than high school
- ☐ High school diploma / GED
- ☐ Some college / Trade school
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Graduate degree
- ☐ Other: _____

Are you currently enrolled in school or training?

- ☐ Yes
- ☐ No

If yes, **Name of School/Program & Area of Study:**

_____

Please provide your work history for the last 5 years:

Company Name	**Position/ Job Title**	**Dates Employed**	**Reason for Leaving**

Are you currently employed?

- ☐ Yes
- ☐ No

If yes, **Where & Position:** _____

Work Schedule (days/hours): _____

Do you have a disability that affects your ability to work?

( ) Yes ( ) No

If yes, **describe disability & needed accommodations for work purposes:** _____

_____

_____

Medical History

Are you currently under a physician's care?

- ☐ Yes
- ☐ No

If yes, for what condition(s)? _____

_____

Primary Care Provider's Name: _____

Primary Care Provider Address, City, Zip Code:

_____

Phone Number: _____

Are there any medical and/or mental health conditions you feel need to be addressed or treated at this time?

- ☐ Yes
- ☐ No

If yes, please explain: _____

_____

Have you ever participated in Medication-Assisted Recovery (MAR)?

If yes, *which medication(s)?*

_____

Do you take any prescription medications?

- ☐ Yes
- ☐ No

If yes, *list each medication, dosage, frequency, route (oral, injection, etc.), and reason for medication (you may attach a printed list if available):*

Medication Name	Dosage	Frequency	Route	Reason for Medication

Do you have any physical limitations or disabilities?

- ☐ Yes
- ☐ No

If yes, please describe:

_____

Do you have any conditions that would prevent you from climbing stairs?

- ☐ Yes
- ☐ No

If yes, please explain:

_____

Do you have any allergies? (medication, food, environmental)

- ☐ Yes
- ☐ No

If yes, list them:

_____

Have you been hospitalized in the last 12 months for medical reasons?

- ☐ Yes
- ☐ No

If yes, please explain:

_____

Do you have any medical needs that would prevent you from living independently?

- ☐ Yes
- ☐ No

Have you ever experienced a Traumatic Brain Injury (TBI)?

- ☐ Yes
- ☐ No

If yes: **Approximate Date of Injury:** _____

Ongoing Symptoms (if any): _____

Have you ever had, or currently have, any of the following? (check and indicate Current or Past)

- ☐ **Diabetes** _____
- ☐ **Hypertension (High Blood Pressure)** _____
- ☐ **Hyperlipidemia (High Cholesterol)** _____
- ☐ **Cancer** _____
- ☐ **Smoking/Tobacco/Vaping Use** _____
- ☐ **Obesity** _____
- ☐ **Asthma** _____

☐ **COPD (Chronic Obstructive Pulmonary Disease)** _____

If indicated "Current" or "Past" for any above, please provide additional details *(diagnosis dates, treatment, provider, etc.):* _____

_____

Do you follow a special diet or have any dietary restrictions?

☐ Yes
☐ No

If yes, please describe (vegetarian, gluten-free, diabetic, religious, food allergies, etc.): _____

Have you been tested for the following?

Test	Have You Been Tested? (Yes/No)	Date (Approx.)	Result (Positive/Negative/Unknown)
HIV	☐ Yes ☐ No		☐ Positive ☐ Negative ☐ Unknown
Hepatitis A/B/C	☐ Yes ☐ No		☐ Positive ☐ Negative ☐ Unknown
Tuberculosis (TB)	☐ Yes ☐ No		☐ Positive ☐ Negative ☐ Unknown
STDs (Gonorrhea, Syphilis, Chlamydia etc.)	☐ Yes ☐ No		☐ Positive ☐ Negative ☐ Unknown

Reproductive Health

Are you currently using any form of birth control?

☐ Yes
☐ No

If yes*, what type?* _____

Are you currently pregnant?

☐ Yes
☐ No
☐ Unsure

If yes, how far along/when is your due date? _____

If yes, who is your doctor? _____

Mental Health History

Have you ever been diagnosed with a mental health condition?

☐ Yes
☐ No

If yes, *please list all diagnoses and indicate whether you were using substances at the time of each diagnosis:*

_____

_____

_____

_____

Have you ever been hospitalized for psychiatric reasons?

☐ Yes
☐ No

If yes, *list dates and facility names:* _____

_____

Have you ever experienced thoughts of suicide?

☐ Yes
☐ No
☐ Prefer not to say

Have you ever made a suicide attempt?

☐ Yes
☐ No

If yes, *when?* _____

Have you ever engaged in self-harm behaviors (e.g., cutting, burning)?

☐ Yes
☐ No

If yes, please describe briefly: _____

_____

Have you ever been diagnosed with or experienced symptoms of a psychotic disorder (e.g., schizophrenia, schizoaffective)?

☐ Yes
☐ No

If yes, which disorder? _____

_____

Are you currently experiencing symptoms of psychosis (e.g., hearing/seeing things, paranoia, delusional thoughts, disorganized speech)?

☐ Yes
☐ No

If yes, please describe briefly: _____

_____

Do you or have you ever had an eating disorder diagnosis?

- ☐ Yes
- ☐ No

If yes, please describe what type: _____

When was the last time you engaged in eating disorder behaviors (restriction, bingeing, purging, excessive exercise, etc.)? _____

Legal History

Do you have any criminal history?

- ☐ Yes
- ☐ No

If yes, please list charges and sentence outcomes below (add rows as needed):

Charge/ Offense	Year	County /State	Sentence/Outcome

Are you currently incarcerated in jail or prison?

- ☐ Yes
- ☐ No

If yes: **Facility Name:** _____

Projected Release Date: _____

Are you currently under any form of community supervision?

- ☐ Yes
- ☐ No

If yes, *check all that apply:*

( ) Probation ( ) Parole ( ) Pretrial Diversion ( ) Drug Court

( ) Re-Entry Program ( ) Other: _____

Probation/Parole/Case Manager Name:

_____

Supervising Agency: _____

Agency Phone Number: _____

Have you ever been charged with or convicted of a sexual offense?

- ☐ Yes
- ☐ No

Have you ever been charged with or convicted of a crime against a child?

- ☐ Yes
- ☐ No

Partner Information (if applicable)

Length of Relationship: _____

Does your current partner use alcohol or other drugs in a way that causes concern for you or affects your well-being?

- ☐ Yes
- ☐ No
- ☐ Unsure

Is your partner supportive of your recovery?

- ☐ Yes
- ☐ No
- ☐ Unsure

Military Service

Have you served in the military?

- ☐ Yes
- ☐ No

Branch & Capacity: _____

Dates of Service: _____

Discharge Status: _____

Is an immediate family member currently serving or has served in the military?

- ☐ Yes
- ☐ No

If yes, please explain:

_____

Trauma History

Please indicate if you experienced any of the following before age 18:

- ☐ Childhood Physical Abuse
- ☐ Childhood Emotional/Mental Abuse
- ☐ Childhood Sexual Abuse

Have you ever engaged in prostitution?

- ☐ Yes
- ☐ No

Are you currently engaged in prostitution?

- ☐ Yes
- ☐ No

If yes, are you working for someone?

- ☐ Yes
- ☐ No

Are you currently in, or have you recently left a living situation where you felt unsafe due to abuse, threats, or controlling behavior by a partner, family member, or someone you lived with?

- ☐ Yes
- ☐ No

In the past, have you experienced feeling unsafe due to abuse, threats, or controlling behavior by a partner, family member, or someone you lived with?

- ☐ Yes
- ☐ No

Have you ever experienced any of the following with your current or previous partner (spouse/girlfriend/boyfriend/significant other)?

- ☐ Yes
- ☐ No

Has he/she ever used a weapon against you or threatened you with a weapon?

Current relationship:

- ☐ Yes
- ☐ No

Previous relationship:

- ☐ Yes
- ☐ No

Has he/she ever threatened to kill you or your children/loved ones/pets?

Current relationship:

- ☐ Yes
- ☐ No

Previous relationship:

- ☐ Yes
- ☐ No

Do you think he/she might try to kill you?

Current relationship:

- ☐ Yes
- ☐ No

Previous relationship:

- ☐ Yes
- ☐ No

Do you have any current concerns about your physical safety or well-being? _____

_____

_____

Recovery Motivation

Instructions: Please circle or mark the number (0–10) that best represents how true each statement feels for you today.

1. I know I have a problem with drugs and/or alcohol.

0 = Not at all

10 = Completely true

0 1 2 3 4 5 6 7 8 9 10

2. I am motivated to make changes in relation to my substance use.

0 = Not motivated at all

10 = Extremely motivated

0 1 2 3 4 5 6 7 8 9 10

3. I believe Dove House can help me address my substance use.

0 = I don't believe it will help

10 = I strongly believe it will help

0 1 2 3 4 5 6 7 8 9 10

Please answer the following open-ended questions:

4. Why do you want to come to Dove Recovery House for Women?

5. What are you hoping to get out of your time in the program?

6. What does recovery mean to you?

Signature & Consent

Please read each statement carefully and initial next to each, indicating your understanding and agreement:

Initials: _____ I agree to a minimum 90-day commitment to the Dove House program.

Initials: _____ I agree to a "still period" during the first 30 days, which includes no movement outside the facility (except court or medical care) and no possession or use of a cell phone. I understand I can access a house phone during this time to make and receive phone calls.

Initials: _____ I understand that during the first 60 days of the program, my primary focus will be my recovery, meetings, and treatment programming, and therefore will be able to begin working outside of the facility only after successful completion of 60 days in the Dove House program once approved.

Initials: _____ I will attend all in-house 12-step recovery meetings as scheduled if I am present at those times.

Initials: _____ I will participate in individual therapy and peer recovery sessions as scheduled.

Initials: _____ I understand that I am committing to a structured residential environment with group participation, assigned chores, curfews, and adherence to community living rules.

I certify that the above information is true to the best of my knowledge. I understand that providing false or misleading information on this application may result in immediate dismissal from the program. I authorize Dove House staff to contact any references listed on this application for the sole purposes of determining eligibility for acceptance into the program.

Printed Name: _____

Signature of Applicant: _____

Date: _____

Staff Signature: _____

Date: _____

Please use this space if needed to provide additional information.

Staff Use Only:

Date Application Received: _____

Admission Approved or Denied: _____

Date Admittance/Denial Letter Sent: _____