

Resilient House

310 W. Central Street

Bluffton, IN 46714

260-273-8821

APPLICATION

Date: _____

Name: _____ DOB: _____ Social Security #: _____

Current Address: _____

Phone Number: _____ Cell Phone Number: _____

Employer: _____ Address: _____ Phone Number: _____

Emergency Contact and Release of Information: (Full Name, City, State, Phone Number & Relation):

Current Treatment Provider: _____ Address: _____

Phone: _____ Primary Counselor: _____ Contact
Number: _____

Length of Stay at Treatment Facility: _____ Tentative Discharge Date: _____

Past Treatment Programs City State Counselor Entry/Exit Date

Have you ever lived in a Half-way, ¾, or Transitional Living Home (Y/N)? ____

Where? _____ When? _____

Substance(s) Used In Past: _____

Substance(s) of Choice: _____ Sobriety Date: _____

Which 12-step recovery program are you working, i.e. AA, NA, CR? _____

What meetings do you attend regularly:

Do you have a Sponsor (Y/N)? ____ If Yes, list your Sponsor's first name and last initial: _____

If no, why not? _____

What is your current source of income? _____ Weekly/Monthly Income: \$ _____

Job Description: _____ How long there? _____

Employer: _____ Address: _____ Phone Number: _____

Do you have a valid driver license or state ID (Y/N)? ____

Do you have a Social Security Card for employment (Y/N)? ____

Do you have a child support obligation (Y/N)? ____ Amount per month? ____ Is your support current (Y/N)? ____

Do you now, or have you ever been in a relationship with a current Resilient House program participant (Y / N)? ____

Who? _____

Pending legal matters (Please explain):

Have you ever been convicted of a felony (Y/N)? If "yes", please explain: _____

Are you currently incarcerated or under community supervision (probation, community corrections) (Y/N)? ____

Are you required to register as a sex /violent offender(Y/N)? ____ Have you been convicted of arson (Y/N)? ____

Do you have any other mental health diagnosis (Y/N)? ____ What is that diagnosis? _____

Have you ever experienced any suicidal ideations, attempts, or received in-patient treatment for self-harming behaviors?

(Y/N)? _____ When? _____

Current Medications and Dosage:

Are you participating in or about to enter a Medicated-Assisted Treatment program (Y/N)?

Please list program name and contact information:

How did you hear about us? _____

Why do you think you are a good fit for a transitional living home?

Applicant's Name Applicant's Signature Date

House Manager's Signature _____

Date

Resilient House

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