Hope GOSPEL MISSION
LIVES RESCUED. REBUILT. RENEWED.

Apply today.

Homeless Services and Addiction Recovery Programs

General

Have you stayed with Hope Gospel Mission before?
☐ Yes ☐ No

(required) **First Name** _____

(required) **Middle Name** _____

(required) **Last Name** _____

Suffix _____

Maiden Name _____

Handicap Status:

☐ Wheel Chair
☐ Walker
☐ Crutches
☐ Unstable Walking
☐ No Handicap
☐ Cane
☐ Blind
☐ Missing Limb
☐ Pregnant
☐ Brace

(required) **Birth Date** ___/___/___

(required) **Gender**

☐ Male ☐ Female
☐ A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culterally specific gender)
☐ Questioning ☐ Do not know

(required) **U.S. Citizen**

☐ Yes ☐ No

(required) **Veteran Status**

☐ Yes ☐ No

(required) **SSN** ___/___/___

(required) **Has Photo ID?**

☐ Yes ☐ No

(required) **Country Where ID Issued**

_____

(required) **State Where ID Issued**

_____

(required) **Ethnicity**

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

(required) **Race**

☐ American Indian, Alaska Native or Indigenous
☐ Asian or Asian American
☐ Black, African American, or African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ N/A

(required) **Primary Language** _____

(required) **How did you hear about the Mission?**

☐ Church Referral
☐ DHS Referral
☐ Other Agency Referral
☐ 211 Referral
☐ Marketing Materials
☐ Street Outreach
☐ Hospital Referral
☐ Jail Referral
☐ Family Referral
☐ Internet Search
☐ Current/Former Resident Referral
☐ Attended Program Presentation
☐ Other _____

New Application

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(required) **Which program are you interested in?**

- ☐ Short Stay
  (Short-term program providing safe shelter, food and clothes. Length of stay varies based on need.)
- ☐ Renewed Hope
  (Long-term homeless and addiction recovery program. Program length is a minimum of 19 months.)

Please read our information booklet for more information on the programming options available.

Known Aliases _____

Mailing Address _____

Suite/Apt _____

City _____

State _____ Zip _____

Best Contact Number _____

Who's phone # is this? _____

Email _____

(required) **What is the last city you stayed in?**

_____

(required) **What is the last state you stayed in?**

_____

(required) **What is the last county you stayed in?**

_____

Homelessness

Do you have a place to stay tonight?

☐ Yes ☐ No

(required) **What was your last place of residence?**

- ☐ A place not meant for habitation
- ☐ Emergency shelter, including hotel/motel paid for with voucher, or RHY-funded Host Home shelter
- ☐ Safe Haven
- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Jail, prison, or juvenile detention facility
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center
- ☐ Residential project or halfway house with no homeless criteria
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Transitional housing for homeless persons (including homeless youth)
- ☐ Host Home (non-crisis)
- ☐ Staying or living in a family member's room, apartment, or house
- ☐ Staying or living in a friend's room, apartment, or house
- ☐ Rental with GPD TIP subsidy
- ☐ Rental with VASH subsidy
- ☐ Permanent housing (other than RRH) for formerly homeless persons
- ☐ Rental with RRH or equivalent subsidy
- ☐ Rental with HCV voucher (tenant or project based)
- ☐ Rental in a public housing unit
- ☐ Rental with no ongoing housing subsidy
- ☐ Rental with no other housing subsidy
- ☐ Ownership with ongoing housing subsidy
- ☐ Ownership with no ongoing housing subsidy
- ☐ Other _____

New Application

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(required) **Length of Stay in Previous Place?**

Where did you sleep before coming to Hope Gospel Mission?

(required) **Are you currently experiencing homelessness?**

☐ Yes ☐ No

Primary reason for homelessness:

- ☐ Criminal Activity
- ☐ Went to Jail/Prison
- ☐ Release from an Institution
- ☐ Substance Abuse
- ☐ Mental Health
- ☐ Medical Condition
- ☐ Physical/Mental Disability
- ☐ Family/Personal Illness
- ☐ For Own Health/Safety
- ☐ Domestic Violence
- ☐ Divorce
- ☐ Hours reduced at work
- ☐ Loss of Job
- ☐ Unemployment
- ☐ Loss of Childcare
- ☐ Loss of Public Assistance
- ☐ Lack of Funds
- ☐ Eviction
- ☐ Mortgage Foreclosure
- ☐ Fire or Other Natural Disaster
- ☐ By Choice
- ☐ Other _____

(required) **Have you been continuously homeless (on the street, in an emergency shelter, or safe haven) for at least one year?**

☐ Yes ☐ No

(required) **How many months in a row have you been without a home, including today?**

Number of times you've been homeless on the street, in an emergency shelter or save haven in the past three years?

Total number of months homeless on the street, in an emergency shelter or save haven in the past three years?

New Application

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(required) **Current Living Situation**

- ☐ A place not meant for habitation
- ☐ Emergency shelter, including hotel/motel paid for with voucher, or RHY-funded Host Home shelter
- ☐ Safe Haven
- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Jail, prison, or juvenile detention facility
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center
- ☐ Residential project or halfway house with no homeless criteria
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Transitional housing for homeless persons (including homeless youth)
- ☐ Host Home (non-crisis)
- ☐ Staying or living in a friend's room, apartment, or house
- ☐ Staying or living in a family member's room, apartment, or house
- ☐ Rental with GPD TIP subsidy
- ☐ Rental with VASH subsidy
- ☐ Permanent housing (other than RRH) for formerly homeless persons
- ☐ Rental with RRH or equivalent subsidy
- ☐ Rental with HCV voucher (tenant or project based)
- ☐ Rental in a public housing unit
- ☐ Rental with no ongoing housing subsidy
- ☐ Rental with no other housing subsidy
- ☐ Ownership with ongoing housing subsidy
- ☐ Ownership with no ongoing housing subsidy
- ☐ Other _____

(required) **Previous Addresses:**

1. Address: _____
   City: _____ State: _____
   Country: _____ ZIP: _____
   Start date: _____ End date: _____
2. Address: _____
   City: _____ State: _____
   Country: _____ ZIP: _____
   Start date: _____ End date: _____
3. Address: _____
   City: _____ State: _____
   Country: _____ ZIP: _____
   Start date: _____ End date: _____

Family

(required) **Marital Status:**

- ☐ Single
- ☐ Married
- ☐ Seperated
- ☐ Widowed
- ☐ Divorced
- ☐ Significant Other

(required) **Spouse's Full Name?**

_____

(required) **Children's Full Name(s) and Age(s)?**

_____

_____

_____

_____

(required) **Relationship to Head of Household:**

- ☐ Self (Head of Household)
- ☐ Child of Head of Household
- ☐ Spouse or Partner to Head of Household
- ☐ Other Relation to Head of Household
- ☐ Other: _____

(required) **Household Size?** _____

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Emergency Contact

(required) **Please list your Emergency Contact:**

1. Name: _____

Relationship: _____

Home Number: _____

Other: _____

Spiritual

Do you consider yourself a Christian?

☐ Yes ☐ No

Please describe your spiritual condition:

_____

_____

_____

_____

(required) **Are you comfortable participating in a faith-based program?**

☐ Yes ☐ No

What is the name of the last church you attended, if applicable?

_____

Medical

(required) **Please check any mental health conditions you have been diagnosed with, even if not current:**

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Bipolar
- ☐ Cutting
- ☐ Depression
- ☐ Eating Disorder
- ☐ MPD
- ☐ Personality Disorder
- ☐ Psychosis
- ☐ Schizophrenia
- ☐ Other _____

(required) **Please check any medical conditions you have been diagnosed with, even if not current:**

- ☐ Asthma
- ☐ Back Injury
- ☐ COPD
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Hearing Problems
- ☐ Heart Disease or Condition
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Other _____

(required) **Today on a scale of 0-5 with 0 meaning zero thoughts of harming yourself and 5 meaning "Please take me to the hospital for help", where would you rate yourself?**

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5

(required) **Are you currently pregnant?**

☐ Yes ☐ No

If yes, what is your expected due date?

___/___/___

(required) **Have you ever attempted suicide?**

☐ Yes ☐ No

If yes, what was the date of your last attempt?

___/___/___

(required) **Are you currently covered by health insurance?**

☐ Yes ☐ No

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Source of Health Insurance:

Medicaid

☐ Yes ☐ No

Medicare

☐ Yes ☐ No

State Children's Health Insurance Program

☐ Yes ☐ No

Veteran's Administration (VA) Medical Services

☐ Yes ☐ No

Employer-Provided Health Insurance

☐ Yes ☐ No

Health insurance obtained through COBRA

☐ Yes ☐ No

Private Pay Health Insurance

☐ Yes ☐ No

State Health Insurance for Adults

☐ Yes ☐ No

Indian Health Insurance

☐ Yes ☐ No

Other Insurance, please specify:

_____

☐ Yes ☐ No

Do you have any dental needs?

☐ Yes ☐ No

Do you have any vision needs?

☐ Yes ☐ No

(required) **Do you need immediate medical attention?**

☐ Yes ☐ No

Is there any additional information you'd like to share about your current medical condition?

_____

_____

Please list all medications that you are taking, and any prescribed medications that you are not currently taking:

_____

_____

_____

_____

Is there any additional information you'd like to share about your previous medical conditions?

_____

_____

Is there any additional information you'd like to share about your dependent's medical conditions?

_____

_____

(required) **Please list any allergies you have, including medication and food:**

_____

_____

(required) **Do you have any medical history that should be known in a medical emergency?**

_____

_____

(required) **Do you have any disabilities?**

☐ Yes ☐ No

(required) **Do you currently have any physical disabilities?**

☐ Yes ☐ No

If yes, please explain disabilities and/or restrictions and/or accommodations that are needed:

_____

_____

Is the physical disability expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?

☐ Yes ☐ No

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(required) **Do you currently have any developmental disability?**

☐ Yes ☐ No

Is the developmental disability expected to substantially impair your ability to live independently?

☐ Yes ☐ No

(required) **Do you currently have a chronic health disability?**

☐ Yes ☐ No

Is the chronic health condition expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?

☐ Yes ☐ No

(required) **Do you currently have HIV/AIDS?**

☐ Yes ☐ No

(required) **Do you currently have a mental health disorder?**

☐ Yes ☐ No

Is the mental health disorder expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?

☐ Yes ☐ No

(required) **Do you have a communicable disease?**

☐ Yes ☐ No

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Addictions / Treatment

Are you a cigarette/pipe smoker?

☐ Yes ☐ No

(required) **Please indicate which of the following might be addiction issues for you:**

- ☐ Alcohol
- ☐ Caffeine
- ☐ Co-Dependency
- ☐ Cocaine
- ☐ Exercise
- ☐ Food
- ☐ Gambling
- ☐ Gaming
- ☐ Internet
- ☐ Marijuana
- ☐ Meth
- ☐ Money
- ☐ Opiates
- ☐ Other Illegal Drugs
- ☐ Other Meds (Prescription)
- ☐ Pornography
- ☐ Religion
- ☐ Sex
- ☐ Sugar
- ☐ Television
- ☐ Theft
- ☐ Tobacco/Nicotine
- ☐ Unhealthy Relationships
- ☐ Work
- ☐ Other _____

When was the last time you used drugs or alcohol?

___/___/___

(required) **Do you currently have a substance use disorder?**

☐ Yes ☐ No

Is the substance use disorder problem expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?

☐ Yes ☐ No

Are you currently receiving services/treatment for this condition?

☐ Yes ☐ No

(required) Current drug of choice?

_____

Total number of times admitted to a treatment center?

_____

Substance Abuse List:

1. Drug/Substance:_____

Frequency of Use:_____

Method of Use:

- ☐ By Mouth
- ☐ Inter-Muscular
- ☐ Transdermal
- ☐ Intravenous
- ☐ Other _____

Date first used: ___/___/___ Date last used: ___/___/___

2. Drug/Substance:_____

Frequency of Use:_____

Method of Use:

- ☐ By Mouth
- ☐ Inter-Muscular
- ☐ Transdermal
- ☐ Intravenous
- ☐ Other _____

Date first used: ___/___/___ Date last used: ___/___/___

3. Drug/Substance:_____

Frequency of Use:_____

Method of Use:

- ☐ By Mouth
- ☐ Inter-Muscular
- ☐ Transdermal
- ☐ Intravenous
- ☐ Other _____

Date first used: ___/___/___ Date last used: ___/___/___

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Treatment Center Admission List:

1. Treatment Center Name:_____

Address:_____

City:_____ State:_____

Country:_____ ZIP:_____

Date admitted: __/__/__ Date released: __/__/__

2. Treatment Center Name:_____

Address:_____

City:_____ State:_____

Country:_____ ZIP:_____

Date admitted: __/__/__ Date released: __/__/__

3. Treatment Center Name:_____

Address:_____

City:_____ State:_____

Country:_____ ZIP:_____

Date admitted: __/__/__ Date released: __/__/__

Employment / Education

(required) **Did you attend any special education classes while in school?**

☐ Yes ☐ No

(required) **Have you ever been diagnosed with a learning disability, such as dyslexia?**

☐ Yes ☐ No

(required) **Are you able to work?**
(even with restrictions)

☐ Yes ☐ No

If you are unable to work, please describe the circumstances:

_____

_____

(required) **Do you have your high school diploma or GED?**

☐ Yes ☐ GED ☐ No

(required) **Do you have any post high school education?**

☐ None ☐ Some
☐ Certificate ☐ Associate's
☐ Bachelor's ☐ Master's
☐ Doctorate

Please list post high school education details:

_____

_____

Is there any additional employment background information you'd like to share?

_____

_____

_____

Financial

(required) **Do you have a checking and/or savings account?**

☐ Yes ☐ No

(required) **Are you receiving food share benefits?**

☐ Yes ☐ No

(required) **Do you have any active credit cards?**

☐ Yes ☐ No

(required) **Do you receive Social Security benefits?**

☐ Yes ☐ No

(required) **Are you responsible for paying child support?**

☐ Yes ☐ No

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(required) **Do you currently receive income from any source?**

☐ Yes ☐ No

Source of income:

Unemployment Insurance

Receiving income from this source?

☐ Yes ☐ No

$:_____.00

Retirement Income from Social Security

Receiving income from this source?

☐ Yes ☐ No

$:_____.00

Social Security Disability Insurance (SSDI)

Receiving income from this source?

☐ Yes ☐ No

$:_____.00

Supplemental Security Income (SSI)

Receiving income from this source?

☐ Yes ☐ No

$:_____.00

Alimony or other spousal support

Receiving income from this source?

☐ Yes ☐

$:_____.00

Child Support

Receiving income from this source?

☐ Yes ☐

$:_____.00

Earned Income (Employment Income)

Receiving income from this source?

☐ Yes ☐

$:_____.00

Pension or retirement income from a former job

Receiving income from this source?

☐ Yes ☐

$:_____.00

General Assistance (GA)

Receiving income from this source?

☐ Yes ☐

$:_____.00

Temporary Assistance for Needy Families (TANF)

Receiving income from this source?

☐ Yes ☐

$:_____.00

Worker's Compensation

Receiving income from this source?

☐ Yes ☐

$:_____.00

Private disability insurance

Receiving income from this source?

☐ Yes ☐

$:_____.00

VA Non-Service-Connected Disability Pension

Receiving income from this source?

☐ Yes ☐

$:_____.00

VA Service-Connected Disability Compensation

Receiving income from this source?

☐ Yes ☐ No

$:_____.00

Other source. Please specify

Receiving income from this source?

☐ Yes ☐ No

$:_____.00

(required) **Do you currently receive non-cash benefits from any source?**

☐ Yes ☐ No

Supplemental Nutrition Assistance Program (SNAP)

☐ Yes ☐ No

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

☐ Yes ☐ No

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TANF Child Care services
(or local child care services)

☐ Yes ☐ No

TANF transportation services
(or local transportation services)

☐ Yes ☐ No

Other TANF-Funded Services
(or other locally funded services)

☐ Yes ☐ No

Section 8, Public Housing, or other
ongoing rental assistance

☐ Yes ☐ No

Temporary rental assistance

☐ Yes ☐ No

Other source, please specify

_____

☐ Yes ☐ No

Vehicle Ownership:

License Plate:_____ Year:_____

Make:_____ Model:_____

Car Insurance Company:_____

Policy Number:_____

Car Location:_____

Legal

(required) **Have you ever been convicted of any non-violent crimes?**

☐ Yes ☐ No

(required) **Have you ever been convicted of any crimes that include violence?**

☐ Yes ☐ No

(required) **Do you have any warrants for your arrest?**

☐ Yes ☐ No

(required) **Are you a registered sexual offender?**

☐ Yes ☐ No

(required) **Are you on probation or parole?**

☐ Yes ☐ No

If yes, Agent's Name:

_____

What is your reporting county?

_____

Agent's Contact Number:

_____

Probation Agent Email:

_____

Parole Agent Name:

_____

Parole Agent Phone:

_____

Parole Agent Email:

_____

(required) **Are you currently incarcerated?**

☐ Yes ☐ No

If yes, which facility are you in?

_____

When is your anticipated release date?

____/____/____

(required) **Are you a domestic violence victim/survivor?**

☐ Yes ☐ No

When did the experience occur?

☐ Within the past three months ☐ Three to five months ago

☐ Six to eleven months ago ☐ 1 year ago or more

Are you currently fleeing?

☐ Yes ☐ No

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Please explain any convictions on your record:

(required) **Do you have any pending legal action?**

☐ Yes ☐ No

Please explain any pending legal action:

Outlook on Life

(required) **Hope Gospel Mission promotes a peer supported environment where residents can openly share their struggles, cultivating a sense of purpose that motivates their recovery process. Do you believe this type of environment would be beneficial for you? If so, how do you see yourself contributing to this healthy, healing community?**

(required) **What is going well in your life right now?**

(required) **What is not going well in your life right now?**

(required) **What are at least three of your strengths?**

1.

2.

3.

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(required) **What are at least three of your weaknesses?**

1. _____

2. _____

3. _____

(required) **Please list three specific goals that you feel you can achieve within the length of the program you are applying for:**

1. _____

2. _____

3. _____

(required) **Why are you applying to Hope Gospel Mission? What type of help would you like to receive from Hope Gospel Mission?**

Acknowledgments

(required) **I acknowledge that I have read or will read the information booklet and agree to follow the guidelines while staying at Hope Gospel Mission.**

☐ Yes ☐ No

(required) **I understand and commit to following the rules without seeking loopholes or attempting to hide my behaviors. I recognize that the funds donated to the Mission are a contribution made by others to support my recovery and goals, and I will honor this gift by taking my program seriously.**

☐ Yes ☐ No

(required) **During my stay at Hope Gospel Mission, I acknowledge and fully understand the zero-tolerance policy regarding drugs and alcohol. I commit to refraining from using or possessing these substances for the duration of my program. Additionally, I agree to help maintain a safe environment by not exposing other residents to these temptations.**

☐ Yes ☐ No

(required) **I understand that Hope Gospel Mission is a faith-based ministry, and I commit to refraining from negative comments, swearing, inappropriate discussions about sexual topics, gossip, sowing discord, discouraging remarks, threats, teasing, harassment, and similar behaviors for the duration of my stay.**

☐ Yes ☐ No

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(required) **I understand the Mission does not require me to be a Christian to participate or complete my programming, but I agree to be mindful of my words and actions to ensure a respectful environment for those pursuing their recovery in this faith-based setting.**

☐ Yes ☐ No

(required) **I commit to upholding the intentional, faith-based, healthy, healing, community that Hope Gospel Mission is striving to build. I recognize my responsibility in helping create a safe and healing environment that encourages the recovery and goal achievement of others.**

☐ Yes ☐ No

(required) **I agree to uphold Hope Gospel Mission's code of conduct, which includes creating a supportive community where people treat each other in a kind, gentle, patient, tolerant, forgiving, respectful, and encouraging way.**

☐ Yes ☐ No

(required) **I understand that violence, harassment, and theft are unacceptable and will not be tolerated while at Hope Gospel Mission.**

☐ Yes ☐ No

(required) **I agree to diligently pursue my program goals.**

☐ Yes ☐ No

(required) **I agree to share any concerns with the appropriate staff for my own protection and the protection of the community.**

☐ Yes ☐ No

(required) **I agree that the information provided in this application is accurate and complete, to the best of my ability.**

☐ Yes ☐ No

(required) **I am open and ready to discuss my situation with staff that will help me create plans to reach my goals, and I agree not to hold back information.**

☐ Yes ☐ No

(required) **I understand that character and attitude are key components to reaching my goals, and I am willing to discuss goals in these areas.**

☐ Yes ☐ No

(required) **I have reviewed the programs and believe that these goals, within a structured environment, will contribute to my successful program completion.**

☐ Yes ☐ No

(required) **I recognize that there may be moments when I feel tempted to give up, but I commit to reaching out to staff for support in navigating these feelings and staying focused on my goals.**

☐ Yes ☐ No

(required) **Signature:**

_____

(required) **Date:**

____/____/____