



HOPE HOUSE 
 CHANGING LIVES THROUGH
 EMPOWERMENT, ENCOURAGEMENT & LOVE

3500 Missouri Flat Road
 Placerville, Ca 95667
 Phone: 530-622-3231 ext 242

Fax application to: wearehopehouse@gmail.com

Thank you for inquiring about our Program.

You show a desire and determination to change your circumstances by applying for the Hope House Program. We admire your courage and are here to help you succeed.

Prior to submitting your application, please make sure you have the following:

1. **Read our Policies and Procedures found on our website**
2. **Completed this application in full; all questions answered**
3. **Written essay (In your essay please include the following: *What* circumstances (in detail) brought you to feel that you need a program like ours; and *Why* you feel that the Hope House Program will benefit you and your family.)**
4. **Two letters of recommendation (from prior programs or people (other than relatives) stating *how* they know you and *why* you would benefit from the Hope House program.)**

Submit your application via fax to: wearehopehouse@gmail.com or turn in to Green Valley Community Church @ 3500 Missouri Flat Rd. Placerville, CA 95667

We ask that you are completely honest when filling out this application. We will not necessarily deny your application based on criminal, substance abuse or housing history, but we may, however, deny it if the information you give us is falsified. Thank you!

Your application will not be accepted *unless it is filled out completely and your essay and references have been received*. You will also be required to submit to a drug-screening test. Please know that you may have to wait up to four weeks for an appointment for an assessment interview with the Executive Director and Programming Team.

Reference Information		
Please list references, telephone numbers, and how these people know you.		
Name	Telephone	Relationship/Yrs. Known

Executive Director, Hope House
wearehopehouse.com



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Application Information (To be filled out by potential client. Please use ink.)		
First Name	Last Name	
Middle Name	Any names you were previously known by	
Date of Birth	Social Security Number	
Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where are you currently staying (include address below)? How Long have you been there?	
City	State	Zip
Staying with Friends or Family?	How long can you stay?	Do you own a vehicle? Where is it at?
Do you have a Driver's License? DL #:	Telephone Number: Is it safe to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is best day/times to call to talk?
What is the highest level of education you have completed? Why?		
Where did you go to High School? What county was this in?		
Did you graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have your G.E.D.? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, do you want one? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship Information		
Marital status/Relationship Status:	If Married, Name of Spouse:	
Where does your Spouse live? How long have you been in a relationship with them?		
Are you currently in a relationship? If yes, please write their name, where they live and how long you have been in a relationship: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, do you understand they can not come to Hope House with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you understand that you are not allowed to be in a relationship while staying at Hope House? <input type="checkbox"/> Yes <input type="checkbox"/> No		
How many people total (include if you are currently pregnant) will need to be housed?		
Emergency Contact:	Relationship/Telephone:	
Address:		



Information on your children: (list all children from eldest to youngest)(3-4 MAX depending on room occupancy):						
1. First Name		Last Name		MI	Age	DOB
Is this child living with Mother? <input type="checkbox"/> Yes <input type="checkbox"/> No		Father's Name:				
Custody Status:	Mother	Father	Relative	Guardianship	Foster Care	
List any schools your child has attended or is attending:						
2. First Name		Last Name		MI	Age	DOB
Is this child living with Mother? <input type="checkbox"/> Yes <input type="checkbox"/> No		Father's Name:				
Custody Status:	Mother	Father	Relative	Guardianship	Foster Care	
List any schools your child has attended or is attending:						
3. First Name		Last Name		MI	Age	DOB
Is this child living with Mother? <input type="checkbox"/> Yes <input type="checkbox"/> No		Father's Name:				
Custody Status:	Mother	Father	Relative	Guardianship	Foster Care	
List any schools your child has attended or is attending:						
4. First Name		Last Name		MI	Age	DOB
Is this child living with Mother? <input type="checkbox"/> Yes <input type="checkbox"/> No		Father's Name:				
Custody Status:	Mother	Father	Relative	Guardianship	Foster Care	
List any schools your child has attended or is attending:						
Do your children have visitation with their father(s)? If yes, what is the agreement and where do visitations take place?						
Do any of your children have special needs? (Physical, Emotional, Mental or Educational (i.e. IEP's, Special Ed)? if so please explain:						
Are there current custody issues or concerns? If so, please describe. Do you receive child support for your children?						
If you do not have custody, is it an option to get your children back? <input type="checkbox"/> Yes <input type="checkbox"/> No		What is the timeframe for reunification with you children?				
What goals/court orders need to be accomplished to get your children back?						



Legal Information		
Are you on probation/parole? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Name of Officer	Telephone Number
Are you a registered sex offender? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Name of Officer	Telephone Number
Do you have an open CPS case? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Name of Case Manager	Telephone Number
Have you ever enrolled or completed court programs instead of conviction or jail time? <input type="checkbox"/> Yes <input type="checkbox"/> No	List all dates/details:	
Have you ever been convicted of a crime? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please explain in detail/charges (Use additional sheets if necessary):	
Have you ever served jail or prison time? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please provide dates/locations:	
Have you ever been a victim of domestic violence? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date and location of last incident:	
Are you currently in danger of domestic violence? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe the situation:	
Do you have any upcoming criminal court dates? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe the situation and what county:	
Do you have any upcoming civil court dates? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe the situation and what county:	
Do you have any upcoming cps court dates? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe the situation and what county:	
Do you have a Temporary Restraining Order <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe the situation:	
Do you have any legal fines? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much and where are they owed?	
Counseling/Therapy Information		
Have you been in counseling the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what reasons - please be specific:	
Are you currently seeing a therapist or involved in group therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who do you see and where do you go:	
If no, are you willing to participate in support groups or one-on-one counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe your need:	
Do you feel that you will be able to commit to being in a shared living facility with your family for a 18 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		



Health Information			
Do you or any of your children that will be living or staying at Hope House have health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe the situation:		
Please list all prescription medications. Use back of sheet if necessary.			
Name of Family Member	Medication	Purpose	
Name of Family Member	Medication	Purpose	
Name of Family Member	Medication	Purpose	
Name of Family Member	Medication	Purpose	
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Name of Company:	Type of Coverage:	
Have you ever been hospitalized other than childbirth? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what reason(s)?		
Have you been tested for?	HIV TB	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Results: Results:
Have you ever had any of the following? (Please circle) Hepatitis Asthma V.D. Ulcers Cancer Heart Trouble Diabetes Epilepsy Other (Please specify): If you answered yes to Hep C, will you try to do treatment while in our program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Recovery Information			
Do you smoke cigarettes? How much per day? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you aware that Hope House is a non-smoking program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you are accepted are you willing to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*HH will allow The Patch for first 30 days.</i>	
Have you ever had a drinking/drug/meds problem? <input type="checkbox"/> Yes <input type="checkbox"/> No What is your Clean Date:	If yes, what, how much and how often?		
Do you have a sponsor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what step are you on?	What age were you when you started drinking/drugs?		
Have you ever had sobriety and relapsed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long did you maintain sobriety and what situation caused you to relapse?		
Have you ever been in a Detox/Rehab program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, where? Explain reason, date, how long and treatment:		



Financial Information (The first 6 months of the Hope House Program require that that you aren't working, since you will be taking full-time classes etc.)				
Employment Status (Select one)	<input type="checkbox"/> Full Time (35 hours or over) <input type="checkbox"/> Part Time (up to 35 hours) <input type="checkbox"/> Never been employed <input type="checkbox"/> Unemployed			
Day last worked:	Individual Gross Monthly Income: \$	Household Gross Monthly Income: \$		
Income Types: Please specify amount next to each item as it pertains.	<input type="checkbox"/> No Financial Resources	\$	<input type="checkbox"/> Food Stamps	\$
	<input type="checkbox"/> Veterans Benefits	\$	<input type="checkbox"/> Unemployment Benefits	\$
	<input type="checkbox"/> Family/Friends	\$	<input type="checkbox"/> Calworks	\$
	<input type="checkbox"/> General Assistance GA	\$	<input type="checkbox"/> Child Support	\$
	<input type="checkbox"/> Social Security	\$	<input type="checkbox"/> WIC	\$
	<input type="checkbox"/> Social Sec. Disability Income SSC	\$	<input type="checkbox"/> Other (specify)	\$
	<input type="checkbox"/> Supplemental Sec. Income SSC	\$		\$
Have you timed out of CalWorks <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, time out date:			
Do you have a Checking /Savings Account? If yes, please specify amounts: <input type="checkbox"/> Yes <input type="checkbox"/> No \$	Are you able to open a bank account? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, why?		
Estimate the amount of debt you owe, if any (e.g.: credit cards, car, utilities, medical, traffic tickets, court fines, etc.).				
Creditor:	Amount Owed	Please circle Current Past Due		
Creditor:	Amount Owed	Please circle Current Past Due		
Creditor:	Amount Owed	Please circle Current Past Due		
Creditor:	Amount Owed	Please circle Current Past Due		
Creditor:	Amount Owed	Please circle Current Past Due		
Are you aware of the monthly Program fee of up to \$200 per month? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you aware of the one time Security Deposit of up to \$100? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever applied for a housing voucher program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which one? When?			
Have you ever been evicted? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please describe and share who the landlord was, where you were living and when this occurred:			
Do you owe money for evictions? <input type="checkbox"/> Yes <input type="checkbox"/> No	What amount or estimated amount do you owe?			



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Goals

Please list five goals you would like to achieve in the next 12-24 months. Please include why these goals are important to you.

1.

2.

3.

4.

5.

General Information

Describe yourself, your family history, and your relationship with the person(s) who have abused you.



Written Consent for Disclosure of Information

I, _____
 (Name)

Allow the following people or agencies permission, to release information and discuss my case with the Director/Program Manager/Programming Team at Hope House.

Please check all boxes that pertain to you and your case:

<input type="checkbox"/> Department of Health and Human Services <input type="checkbox"/> Child Protective Services <input type="checkbox"/> Mental Health Agency and/or Psychiatrist <input type="checkbox"/> The Center of Violence Free Relationships <input type="checkbox"/> Other Domestic Violence Project/Shelter <input type="checkbox"/> Law Enforcement/Probation;Parole Officer <input type="checkbox"/> Drug/Alcohol Counselor	<input type="checkbox"/> Lawyer <input type="checkbox"/> Early Head Start <input type="checkbox"/> Child’s School/Day Care <input type="checkbox"/> Mother Teresa’s Maternity Home <input type="checkbox"/> Progress House <input type="checkbox"/> Hope House <input type="checkbox"/> Other: _____
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 Signature Date

Please read and initial the next four statements:

_____ I understand that Hope House is a faith-based program with a spiritual component included throughout.

_____ I understand Hope House is a drug/smoke free environment and that should I be accepted into the program, I will not be allowed smoke cigarettes/vape etc. once in the program. I will be allowed to use the patch for 30 days once I move if I need help to quit.

_____ I understand that I may disqualify myself for admission into the Hope House program if I provide false or fraudulent information.

_____ I give permission to Hope House staff and representatives to verify information I have given in this application and to release and communicate with other helping organizations to coordinate services.

_____ I have read the Hope House Policies and Procedures found on their website: wearehopehouse.com and feel that I can adhere to these rules if I am accepted into the program.

Date Application Submitted: _____