

**House of Hope, A Ministry of Starting Point Outreach Center, Inc.  
117 Myrtle Avenue, Willard, Ohio 44890 Phone: 419-933-4100, Fax 419-935-8632  
House of Hope Application**

House of Hope is a Level 2 sober living residence in Willard, Ohio. Our mission is to help men who are in recovery from drug and alcohol abuse become productive members of their community by providing transitional housing and support.

House of Hope is designed for male participants with a minimum of thirty days demonstrated sobriety who are committed to sober living with like-minded persons. Huron County residents are preferred, residents from other counties will be considered on a space available basis. The house has a capacity for five participants including a Senior Resident lives in and oversees the house. Anticipated length of stay is one year.

House of Hope is operated by the Starting Point Outreach Center, Inc., 117 Myrtle Avenue, Willard, Ohio; an Ohio corporation for non-profit. Starting Point has existed in the community since 2010, providing support to persons and families in times of crisis. Starting Point is a faith-based organization that enjoys strong relationships with Willard businesses, churches, government and law enforcement.

For persons who are exiting a thirty-day rehabilitation program the recommended timing is as follows:

1. Complete and submit application, HIPAA release, Requirements-Rules-Rights document by day seven. Ensure the applicant has a valid driver's license or state ID for background check. Make arrangements for financial support.
2. House of Hope will schedule a preliminary interview by day fourteen.
3. House of Hope will conduct a formal interview by day twenty-one. A face-to-face interview at the rehabilitation facility is preferred.
4. If accepted, transport to House of Hope on day thirty.

The application, HIPAA form, and Requirements, Rules and Rights for participation, as well as additional contact information, can be found online at <http://www.startingpointoc.org/house-of-hope.html>

Please direct inquiries to:

Donald Peeler, Executive Director, Starting Point Outreach Center  
Email: [dpeeler@startingpointoc.org](mailto:dpeeler@startingpointoc.org)

Michael Bell, House of Hope Project Manager  
Email: [mbell@startingpointoc.org](mailto:mbell@startingpointoc.org)

Phone: 419-933-4100

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**Applicant Information and Personal History:**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Current Address: \_\_\_\_\_

What type of housing is this? \_\_\_\_\_

Previous Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_ (h) \_\_\_\_\_ (c)

What is your sobriety date and how can it be verified? \_\_\_\_\_

\_\_\_\_\_

Name, address and phone of your caseworker/counselor: \_\_\_\_\_

\_\_\_\_\_

Valid Driver's License or State ID:  Yes  No DL/ID Number: \_\_\_\_\_

Your highest level of education: \_\_\_\_\_

Are you a registered sex offender?  Yes  No

Have you ever been charged with or convicted of a sex offense?  Yes  No

Have you ever been charged with or convicted of arson?  Yes  No

Please Check any/all of the following that apply to you:

Pending Court Case: \_\_\_\_\_

On Probation

On Post Release Control (Parole)

Have a Criminal History. If checked, please list all offenses and dispositions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Name and telephone number of probation officer: \_\_\_\_\_

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Have you ever served in the military?  Yes  No

Do you have a significant other?  Yes  No

Please provide their name and contact information: \_\_\_\_\_

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Please provide the names and ages of any children that you have, and indicate if you have custody of those children:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Custody:  Yes  No

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Custody:  Yes  No

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Custody:  Yes  No

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Custody:  Yes  No

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Custody:  Yes  No

Do you owe or pay child support?  Yes  No Total/Monthly Amount: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Employment and Financial Information:**

Are you employed?  Yes  No

Attending school?  Yes  No

If yes, please list the name, address, and phone number of your employer or school:

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Full-time  Part-time Position: \_\_\_\_\_ Rate of Pay: \_\_\_\_\_

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Supervisor's Name and Phone Number: \_\_\_\_\_

\_\_\_\_\_  
If not employed, list date and place of last employment. \_\_\_\_\_

\_\_\_\_\_  
If you and/or your household are receiving any of the benefits listed below, please check all that apply, and list the monthly amount received:

Disability:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount: \$ _____
Food Stamps:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount: \$ _____
ADC:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount: \$ _____
Unemployment:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount: \$ _____

Do you have insurance?  Yes  No  
    Medicare?  Yes  No  
    Medicaid?  Yes  No

Insurance Provider: \_\_\_\_\_

Are you able to pay the participation fee and purchase your own food for House of Hope participation?  Yes  No

Do you agree to attend weekly 12 Step Meetings?  Yes  No

Do you agree to participate in activities that take place in the home (such as house meetings and other support and learning opportunities)?  Yes  No

Do you agree to contribute to the care of the household (such as doing chores, taking care of the house and lawn, cooking, and cleaning up after yourself)?  Yes  No

What date do you expect to be available for participation? \_\_\_\_\_

What goals would you like to achieve in the next year?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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What are your expectations of the *House of Hope* Recovery Program?

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How did you learn about House of Hope?

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Provide contact information for the person(s) you authorize us to contact in the event of a medical emergency or if you are terminated from program participation.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Please provide any other information that should be known about you or your situation.

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I, \_\_\_\_\_ (Applicant Printed Name), declare that all of the foregoing statements of information are true and correct. I acknowledge that falsification of information may result in not being accepted into or dismissed from House of Hope participation. I authorize the release of this information sufficient to obtain a background check and other means necessary to verify all or part of the information I have provided. I authorize contacting the above mentioned person(s) in the event of a medical emergency or termination from participation.

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Applicant Signature

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Date