Mail to:

Olivia's House of Hope
P.O. Box 105
212 26th St. South
Olivia, MN 56277

Compassionate Christian Housing for Women

Program Application   CONFIDENTIAL

Full Name: _____   Date: _____
Last   First   M.I.

Address: _____
Street Address   Apartment/Unit #

_____
City   State   ZIP Code

Phone: _____   Email_____

Approx. Date of release and/or arrival: _____

	YES	NO		YES	NO
Are you a citizen of the United States?	☐	☐	If no, are you authorized to work in the U.S.?	☐	☐

Are you currently in a treatment facility?   YES ☐   NO ☐   If yes, explain_____

Are you currently in a Correctional facility?   YES ☐   NO ☐   If yes, explain:_____

Marital status/children: _____

Education

High School or GED? _____   Date/Year?_____

Did you graduate?   YES ☐   NO ☐

College: _____   Address:_____

From: _____   To:_____   Did you graduate?   YES ☐   NO ☐   Degree:_____

Other: _____   Address:_____

From: _____   To:_____   Did you graduate?   YES ☐   NO ☐   Degree:_____

References

Please list contact info for case worker, personal reference, professional counselor etc..

Name: _____ Relationship/Title:_____

Organization: _____ Phone:_____

Address: _____

Name: _____ Relationship/Title:_____

Organization: _____ Phone:_____

Address: _____

Name: _____ Relationship/Title:_____

Organization: _____ Phone:_____

Address: _____

Previous Treatments

Facility: _____ Date:_____

Treated for: _____ Completed?:_____

Facility: _____ Date:_____

Treated For: _____ Completed?

Others?: _____

May we contact your previous facilities for a reference?   YES ☐   NO ☐

Criminal Background

Are you currently on probation/parole? _____ County?:: _____

Any Court Cases Pending? _____ If yes, explain: _____

Ever Convicted of Violent Crime?: _____ If yes, explain EACH conviction _____

_____

Any Sex Related Crimes?:_____ If yes, explain in full: _____

Do you have any outstanding warrants?   YES ☐   NO ☐

_____

Probation/Parole Officers name: _____ Phone:_____

Address: _____ State/Zip _____

Physical Health

Any current medical issues?_____ Any Medications?_____ Any special needs?_____
If yes, explain in detail _____
Physician:_____ Clinic: _____ Phone:_____

What interests you about Olivia's House of Hope?

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Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to enrollment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date:_____