Providence Ministries
Loreto House Application

Accepted to wait list ☐ Denied ☐ Reason: _____

LAST NAME: _____ FIRST NAME: _____ MI: ___

DOB: _____ SS# _____ AGE: _____ STATE ID# _____

COVID-19 VACCINATION: YES _____ NO _____ WILLING TO RECEIVE: _____

COPY OF STATE ID, SOCIAL SECURITY CARD AND VACCINATION CARD REQUIRED WITH SUBMISSION

REFERRAL INFORMATION

Referred by: _____

Contact name & phone number if a bed becomes available: _____

Have you previously been a resident of any Providence Ministries Sober Homes? _____

If yes, when? _____ What house? _____ Primary Language? _____

Occupation? _____ Date last worked? _____

Are you currently on or do you have: Probation ☐ Parole ☐ Case Pending ☐ Warrants ☐
Restraining Order ☐

Probation/Parole Officer: _____ Phone: _____
Court: _____ Phone: _____

Have you ever been convicted of the following? Arson ☐ Murder ☐ Rape ☐ Sex Crimes ☐

Have you been diagnosed with a psychiatric illness? Yes ☐ No ☐

Diagnosis: _____
Psychiatric Hospitalizations? Yes ☐ No ☐

When? _____ Where? _____

Diagnosed Condition(s)? _____

_____

Are you taking prescribed medical and or psychiatric medications? Yes ☐ No ☐

Prescriber: _____ Phone Number: _____

History of Suicide Attempts? Yes ☐ No ☐ When? _____

IV Drug Use? Yes ☐ No ☐ What substance? _____

Date last used? _____

DETOX: Yes ☐ No ☐ Where? _____ When? _____

CSS/TSS: Yes ☐ No ☐ Where? _____ When? _____

Recovery Home Yes ☐ No ☐ Where? _____ When? _____

Outpatient: Yes ☐ No ☐ Where? _____ When? _____

Other: Yes ☐ No ☐ Where? _____ When? _____

Name of Primary Care Physician: _____ Phone: _____

Are you enrolled in a Medically Assisted Treatment Program? Yes ☐ No ☐

Methadone ☐ Suboxone ☐ Other ☐ Dosage? _____

Circle one: Detox or Maintenance Use

Providence Ministries reserves the right to deny ANY misrepresentation on this application and will result in termination of consideration. I certify all information is true and correct to the best of my knowledge.

Printed Name: _____ Date: _____

Signature: _____

Providence Ministries Income Verification Application

Date: _____ Name: _____

Are you currently employed? Yes_____ No _____
Employer: _____ Weekly Income: _____
How do you get paid: Weekly: _____ Bi-weekly: _____ Monthly: _____

Do you receive unemployment? Yes _____ No_____
Amount: _____ Per week: _____ Month _____
How long will you continue to receive Unemployment? _____

Do you receive disability payments? Yes _____ No _____
Amount: _____

Do you receive Social Security or SSI? Yes _____ No _____
What benefits: _____ Amount: _____

Do you have any other income ex. Retirement, annuity, pension...? Yes __No __
Income Type: _____ Amount: _____

Do you currently have the funds needed for your initial payment? Yes __ No __

Do you have Family / Friends that are willing to help pay in an emergency?
Yes _____ No _____
If so what is the relationship: _____

Printed Name: _____ Date: _____
Signature: _____

MEDICATION LIST TEMPLATE

NAME

DATE OF LAST UPDATE

MEDICATION ALLERGIES

MEDICATION LIST

MEDICATION	DOSAGE STRENGTH	FREQUENCY	CONDITION MEDICATION TREATS	PHYSICIAN	NOTES