**Meta House Recovery Community Application (updated 11/3/23)**

*All information on this application must be completed. You will be denied membership if you misrepresent any information on this application. If misrepresentations are found after a membership agreement is signed, your membership agreement will be terminated.*

**Please return application to Robyn Ellis at 2625 N. Weil St. Milwaukee WI 53212, by fax to 414-962-2305, or by email to** **rellis@metahouse.org****. Must also include documentation of** **45 days of sobriety and confirmation of either Milwaukee County bridge funding or plan for self-pay**

**PERSONAL INFORMATION:**

Applicant’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Program \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Housing Needed \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

What is the primary language spoken in your home?

[ ]  English [ ]  Spanish [ ]  Hmong [ ]  Other:

Do you need any help with communicating in English? [ ]  Yes [ ]  No

What is your race? (please check all that apply)

[ ]  Asian

[ ]  Black or African-American

[ ]  Middle Eastern

[ ]  Native American/Alaska Native

[ ]  Native Hawaiian or Other Pacific Islander

[ ]  White

[ ]  Other:

Are you Hispanic/Latinx? [ ]  Yes [ ]  No

How do you identify your gender?

[ ]  Female

[ ]  Trans-woman (male-to-female)

[ ]  Trans-man (female-to-male)

[ ]  Gender queer

[ ]  Gender non-conforming

[ ]  Something else (please specify):

What are your preferred pronouns?

**ADMISSION CRITERIA:**

Have you misused substances, including alcohol, marijuana, and other drugs or misused prescriptions, in the past year? [ ] Yes [ ]  No

* What is/are your drug(s) of choice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have documentation of 45 days of sobriety? [ ] Yes [ ]  No

* If not, do not submit your application until you have achieved 45 days of documented sobriety.

Have you read the RIPLE rule book? [ ] Yes [ ]  No

If you will be utilizing Milwaukee County Bridge Funding (Milwaukee County residents only), has your team requested it or have you been assessed by Milwaukee County? [ ] Yes [ ]  No

What is your plan for paying your membership fee once bridge funding has ended or if you plan to self-pay? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current recommended level of substance use treatment, or if in residential your recommended level of care at discharge (day treatment, IOP, outpatient)? All Members must participate in the recommended level of care in substance use treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your plan for your 20 hours of structured activity each week, including treatment at the recommended level of care, required Meta House services, and weekly non-Meta House support?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Single housing:**

Will any minor children be visiting you in Meta House Recovery Housing? [ ] Yes [ ]  No

* If yes, how many children will visit? What is the visitation schedule?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family housing:** With CPS involvement, Members must have at least one overnight per week with your child(ren) and the goal of reunification or if no CPS involvement must have minimum of 50/50 placement

Are you involved with any of the following?

[ ]  Family Drug Treatment Court [ ]  Healthy Infant Court [ ]  Child Welfare

How many children do you plan to have live with you in the Recovery Community? \_\_\_\_\_\_\_\_\_\_

* What is the plan for reunification? If children are with family or in an informal placement, does that caregiver agree the child(ren) will live with you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you willing to participate in individual parenting services, child and family groups, child assessments, Celebrating Families and/or services recommended for your children? [ ] Yes [ ]  No

How many minor children do you have? \_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Where does your child(ren) currently live? | Is this a legal placement (CPS, transfer of guardianship) by the court or an informal placement? |
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Are you currently pregnant? [ ] Yes [ ]  No [ ]  Refused to Answer [ ]  Unsure

Do you have any current medical conditions and/or physical health problems? [ ] Yes [ ]  No

* If yes, please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco/e-cigarettes/vapes? [ ] Yes [ ]  No

* Note: Meta House is a nicotine-free and vape-free campus

Do you now, or have you ever, received mental health services? [ ] Yes [ ]  No

* If yes, please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you prescribed mental health and/or physical health medications? [ ] Yes [ ]  No

* If yes, do you take your medication as prescribed? [ ] Yes [ ]  No
* Are you willing to accept recommendations from Meta House’s medical team regarding your medication? [ ]  Yes [ ]  No
* Are you prescribed any of the following:

[ ]  Opioids [ ]  Gabapentin [ ]  Zolpidem/Ambien

[ ]  Benzodiazepines [ ]  Pregabalin/Lyrica [ ]  Stimulants (e.g., Vyvanse)

Note: If you are not currently taking these medications, you must consult with Meta House and be approved before starting any of these medications

* List all current mental health and/or physical health medications:

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| --- | --- | --- | --- |
| Medication | Dosage/Times per day | Reason Prescribed | Prescriber |
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When do you have your next appointment scheduled with your prescriber? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note: Meta House does not prescribe medications**

What forms of income do you and your child (ren) receive? (Check all that apply)

[ ]  W-2 (TANF) [ ]  Employment full-time

[ ]  Work training program (Goodwill) [ ]  Employment part-time

[ ]  Social Security – adult [ ]  Child support

[ ]  Social Security – child (ren) List who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Survivor Benefits – child (ren) List who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where are you currently living?

[ ]  Streets/doubled-up [ ]  Residential Treatment

[ ]  Shelter [ ]  Incarceration

[ ]  Living in unsafe and/or short-term arrangement

[ ]  Other bridge-funded housing

[ ]  Other sober living

[ ]  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following?

[ ]  Evictions [ ]  Felonies [ ]  Unpaid Utility bills

Do you own or plan to drive a car?

* Do you have a valid driver’s license? [ ]  Yes [ ]  No
* Is the vehicle registered? [ ]  Yes [ ]  No
* Is the vehicle insured? [ ]  Yes [ ]  No
* Make and Type \_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_ Color \_\_\_\_\_\_\_ Lic. No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Note: You will need to provide copies of your valid driver’s license, current registration of vehicle, and current car insurance at any time you plan to drive a car while living in the Meta House Recovery Community.

Plan last updated on: \_\_\_\_\_\_

**Wellness Plan**

**Name:**  **D.O.B**

**Address:**  **Phone:**

**My team:**

* Therapist: Phone:
* Case manager: Phone:
* Parenting: Phone:
* Child Welfare Worker: Phone:
* Emergency contact: Phone:

**If a lapse occurs, I will call on-call at (414) 840-8101 to invoke the Wellness Plan. I must speak with staff to determine when it is safe for me to return to the Recovery Community.**

**OR**

**In the event of an unplanned discharge and I need to leave the Recovery Community by 3pm I will go to the following place. If my identified location is no longer an option, I understand I will need to call for shelter. If shelter is not available, I understand I will still be discharged.**

I will go with: Phone:

To address:

* First Step Detox 2835 N 32nd St, Milwaukee, WI 53210

Phone: (414) 342-6200

* Columbia St Mary’s 2301 N. Lake Drive, Suite 1407, Milwaukee, WI 53211

Phone: (414) 585-1163

* Froedtert Hospital 9200 W Wisconsin Ave, Milwaukee, WI 53226

Phone: (414) 805-3000

* Wheaton Franciscan Healthcare - St. Francis 3237 S 16th St, Milwaukee, WI 53215

Phone: (414) 647-5000

My child(ren) will go with: Phone:

To address:

I can return to the Meta House housing community at the time determined by staff.

My child(ren) will return when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My medications:**

Prescribing Physician:

Allergies:

**My medications are located in my individual safe**:

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Possible Side Effects** |
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***My Children***

**Child’s Name:**

Date of birth:

School/Daycare (name, address, phone)**:**

Pediatrician (name, address, phone):

Allergies:

Medication:

**Child’s Name:**

Date of birth:

School/Daycare (name, address, phone)**:**

Pediatrician (name, address, phone):

Allergies:

Medication:

**Child’s Name:**

Date of birth:

School/Daycare (name, address, phone)**:**

Pediatrician (name, address, phone):

Allergies:

Medication: