Michael's House Application

Applicant Information			
Name:			
Date of birth	**Email:**	**Phone:**	
Current address:			
City:	**State: MA**	**ZIP Code:**	
Marital Status:	**Projected Move Out Date:**	**Number of Children:**	
Previous address:			
City:	**State:**	**ZIP Code:**	

Recovery Attempts			
Inpatient Treatments:			**Recovery Attempts?**
Fellowship:	**Sponsor:**	**HomeGroup:**	
City:	**State:**	**ZIP Code:**	
Position:	**Hourly Salary (Please circle)**		**Annual income:**

Emergency Contact			
Name:			
Address:			
City:	**State:**	**ZIP Code:**	**Phone:**
Relationship:			

Education and Work History			
Last Grade Completed:	**Name of School**	**Graduated:**	
Occupation:	**Current Work Status:**	**Employer:**	
Employer Phone:	**Employer Address**	**Length**	

Medical			
Primary Care Doctor:			
Address:			**How long?**
Phone:	**Medications:**	**Suicide Attempts:**	
City:	**State:**	**Therapist:**	
Allergies:	**Medical Conditions:**		

Family Contact		
Name:	Address:	Phone:

I authorize the verification of the information provided on this form as to my personal information and employment. This is for application to Michael's House.

Signature of applicant:	Date:

Policy Regarding Guest Use of Medications

Michael's House is not a medical facility and therefore does not employ personnel trained or qualified to render advice or opinions regarding guest's use of medications prescribed by their physicians. Accordingly, it is the policy of Michael's House to offer no opinion or advice on its guest's use of prescribed medications. If a guest at Michael's House is taking medications prescribed by a physician, he should continue following the doctor's advice. In the event a guest wishes to discontinue taking his medication, they must do so under the direction of the prescribing physician.

I state that all information provided in this form is complete and correct, and I authorize Michael's House to verify the information provided and to use it in its evaluation and course of business. If welcomed to Michael's House I could be subject to removal if the above information is found to be incorrect. By signing this form, I also state that I have read and agree with the policy regarding medications, the guest expectations of Michael's House and will abide by and agree with the payment and other policies of Michael's House.

NO REFUNDS. PAYMENT IS FINAL. IF THE GUEST IS ASKED TO LEAVE, FOR ANY REASON, THEY ARE NOT ENTITLED TO A REFUND. THE GUEST IS REQUIRED TO GIVE MICHAEL'S HOUSE FOUR (4) WEEKS NOTICE PRIOR TO MOVING OUT. MICHAEL'S HOUSE WILL THEN APPLY PAYMENTS MADE TO THAT MONTH, IF AND ONLY IF FOUR (4) WEEKS NOTICE IS GIVEN.

AGREED AND ACCEPTED:

_____ Date: _____
(Guest Signature)

_____ Date: _____
(Witness Signature)

IF A THIRD PARTY (e.g., without limitation, parents, spouse, sibling, friend) IS MAKING PAYMENT ON BEHALF OF THE GUEST (the "Payee"), THEIR SIGNATURE BELOW SIGNIFIES THEIR UNDERSTANDING AND AGREEMENT OF THE NO REFUND POLICY.

ALL PAYMENTS ARE FINAL.

THERE ARE NO REFUNDS, NO PRO-RATING, NO EXCEPTIONS. IF THE ABOVE GUEST IS ASKED TO LEAVE, FOR ANY REASON, THERE WILL BE NO REFUNDS.

AGREED AND ACCEPTED:

PAYEE (Signature) _____Date: _____

(Print Name) _____

Relationship to Guest _____