

FLORIDA RECOVERY HOME LOAN APPLICATION

START-UP LOAN FOR SELF-RUN, SELF-SUPPORTED, RECOVERY HOME				CASE NUMBER:	
HOUSE NAME:			NAME OF LANDLORD:		
HOUSE ADDRESS:			ADDRESS OF LANDLORD:		
CITY:		STATE:	ZIP:	CITY:	
STATE:		ZIP:	STATE:		ZIP:
PHONE#:		DOES LANDLORD KNOW PURPOSE OF HOUSE?			PHONE#:
TOTAL AMOUNT REQUESTED \$				MAY NOT EXCEED \$4,000.00	
CONSISTING OF:	FIRST MONTH RENT +	LAST MONTH RENT +	DAMAGE DEPOSIT +	OTHER START UP EXPENSES	
	\$	\$	\$	\$	
DESCRIPTION AND COST OF OTHER START -UP EXPENSES: (ATTACH ADDITIONAL SHEET IF NECESSARY)					
REPAYMENT TERMS (Check one):					
16 MONTHS		12 MONTHS		18 MONTHS	
				24 MONTHS	
LOAN PAYMENTS WILL BE DUE ON THE 15TH OF THE MONTH , AND ARE SUBJECT TO A \$25.00 OR 20% LATE FEE , WHICHEVER IS GREATER. THERE IS A \$25.00 RETURNED CHECK FEE .					
AMOUNT RECEIVED (BALANCE)		AMOUNT DUE MONTHLY		PAYMENT SCHEDULE:	
\$		\$			
TYPE OF HOUSE (check one) FEMALE:			MALE:		DATE OF OCCUPANCY:
TERMS OF LEASE: (No. of Years)		# OF BEDROOMS:		# BATHS:	# OTHER ROOMS:
PROXIMITY TO PUBLIC TRANSPORT:		PROPOSED # OF BEDS:		UTILITIES: (Electric, Gas, Oil)	# PARKING SPACES:
CERTIFICATION AND SIGNATURES: We the undersigned hereby certify that we are recovering from addiction to alcohol and/or other drugs, and that, we are part of a duly recognized non-profit organization. We further certify that we understand that the funds advanced to us under the terms of this program must be repaid according to the schedule agreed to herein, and that the residents of this Recovery Home shall be responsible for prompt monthly payments until the full outstanding balance of the loan is repaid.					
SIGNATURE (A)		DATE	SIGNATURE (E)		DATE
SIGNATURE (B)		DATE	SIGNATURE (F)		DATE
SIGNATURE (C)		DATE	SIGNATURE (G)		DATE
SIGNATURE (D)		DATE	SIGNATURE (H)		DATE
SIGNATURE – SPONSOR/COSIGNER		DATE		SIGNATURE-CONTACT PERSON	DATE
APPLICANT ORGANIZATION		DATE SUBMITTED			

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LOAN APPLICANT A (CONTACT PERSON)			
NAME:	TELEPHONE – DAY:	TELEPHONE – EVENING:	
SSN:	DATE OF BIRTH:		
PRESENT ADDRESS:	CITY, STATE & ZIP:	PRIMARY ADDICTION:	
NAME OF MOST RECENT TREATMENT FACILITY ATTENDED:	COUNSELOR OR CONTACT:	LAST DRINK OR DRUG DATE:	
ADDRESS OF TREATMENT FACILITY:	TELEPHONE NO. OF CONTACT:	DATES IN PROGRAM (From /To):	
NUMBER OF TIMES IN A TREATMENT FACILITY:	CURRENT EMPLOYER:	# OF AA/NA MEETINGS ATTENDED PER WEEK:	
DO YOU TAKE PRESCRIPTION DRUGS? -IF YES LIST:	TOTAL MONTHLY INCOME:	AGE:	SEX:
LOAN APPLICANT B			
NAME:	TELEPHONE – DAY:	TELEPHONE – EVENING:	
SSN:	DATE OF BIRTH:		
PRESENT ADDRESS:	CITY, STATE & ZIP:	PRIMARY ADDICTION:	
NAME OF MOST RECENT TREATMENT FACILITY ATTENDED:	COUNSELOR OR CONTACT:	LAST DRINK OR DRUG DATE:	
ADDRESS OF TREATMENT FACILITY:	TELEPHONE NO. OF CONTACT:	DATES IN PROGRAM (From /To):	
NUMBER OF TIMES IN A TREATMENT FACILITY:	CURRENT EMPLOYER:	# OF AA/NA MEETINGS ATTENDED PER WEEK:	
DO YOU TAKE PRESCRIPTION DRUGS? -IF YES LIST:	TOTAL MONTHLY INCOME:	AGE:	SEX:
LOAN APPLICANT C			
NAME:	TELEPHONE – DAY:	TELEPHONE – EVENING:	
SSN:	DATE OF BIRTH:		
PRESENT ADDRESS:	CITY, STATE & ZIP:	PRIMARY ADDICTION:	
NAME OF MOST RECENT TREATMENT FACILITY ATTENDED:	COUNSELOR OR CONTACT:	LAST DRINK OR DRUG DATE:	
ADDRESS OF TREATMENT FACILITY:	TELEPHONE NO. OF CONTACT:	DATES IN PROGRAM (From /To):	
NUMBER OF TIMES IN A TREATMENT FACILITY:	CURRENT EMPLOYER:	# OF AA/NA MEETINGS ATTENDED PER WEEK:	
DO YOU TAKE PRESCRIPTION DRUGS? -IF YES LIST:	TOTAL MONTHLY INCOME:	AGE:	SEX:
LOAN APPLICANT D			
NAME:	TELEPHONE – DAY:	TELEPHONE – EVENING:	
SSN:	DATE OF BIRTH:		
PRESENT ADDRESS:	CITY, STATE & ZIP:	PRIMARY ADDICTION:	
NAME OF MOST RECENT TREATMENT FACILITY ATTENDED:	COUNSELOR OR CONTACT:	LAST DRINK OR DRUG DATE:	
ADDRESS OF TREATMENT FACILITY:	TELEPHONE NO. OF CONTACT:	DATES IN PROGRAM (From /To):	
NUMBER OF TIMES IN A TREATMENT FACILITY:	CURRENT EMPLOYER:	# OF AA/NA MEETINGS ATTENDED PER WEEK:	
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LOAN APPLICANT E			
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SSN:	DATE OF BIRTH:		
PRESENT ADDRESS:	CITY, STATE & ZIP:	PRIMARY ADDICTION:	
NAME OF MOST RECENT TREATMENT FACILITY ATTENDED:	COUNSELOR OR CONTACT:	LAST DRINK OR DRUG DATE:	
ADDRESS OF TREATMENT FACILITY:	TELEPHONE NO. OF CONTACT:	DATES IN PROGRAM (From /To):	
NUMBER OF TIMES IN A TREATMENT FACILITY:	CURRENT EMPLOYER:	# OF AA/NA MEETINGS ATTENDED PER WEEK:	
DO YOU TAKE PRESCRIPTION DRUGS? -IF YES LIST:	TOTAL MONTHLY INCOME:	AGE:	SEX:
LOAN APPLICANT F			
NAME:	TELEPHONE – DAY:	TELEPHONE – EVENING:	
SSN:	DATE OF BIRTH:		
PRESENT ADDRESS:	CITY, STATE & ZIP:	PRIMARY ADDICTION:	
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LOAN APPLICANT G			
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SSN:	DATE OF BIRTH:		
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LOAN APPLICANT H			
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