Tennessee Alliance of Recovery Residences

Affiliate Application

If you need more space for answers to application questions, please feel free to use a separate sheet. Application forms may be emailed to info@tn-arr.org or faxed to : 615-383-2577. Application material sent by postal or express mail should be addressed to:

TENNESSEE ALLIANCE OF RECOVERY RESIDENCES
PO Box 120114
Nashville, TN 37212-0114
615-500-4434

Section 1: Residence Information

(Check those that apply)

____ *New Affiliate*
____ *Existing Affiliate*

____*Recovery Residence with 1-20 beds*
____*Recovery Residence with 21-40 beds*
____*Recovery Residence with 41-60 beds*
____*Recovery Residence with 60+ beds*

Name of Recovery Residence: _____

Recovery Residence type: _____

City of Recovery Residence: _____State: _____Zip:_____

Service County: _____Website address: _____

Residence is: (check those that apply)

___Owned by affiliate
___ Leased from third party
___ Leased from person or entity related to affiliate

Year founded: _____

Number of bedrooms: _____

Number of bathrooms: _____

Type of Structure: (Check all that apply)

___ Single family home
___ Apartment Building
___ One or more apartment units
___ Condominium unit
___ Duplex or triplex

Other: _____

Level of Support	*Residences*	*Capacity (beds)*
Level 1		
Level 2		
Level 3		
Level 4		

Levels of Resident Support: (Fill out table. For references please see the levels of support description page. (Pg. 5)

Serving**:** (Check all that apply)

_____ Men _____ Co-ed

_____Women _____ Men w/children

_____Women w/children

Food:

____Out of pocket

____Food Stamps

Resident Contribution (monthly): _____

Section II: Affiliate Information

Affiliate/Applicant name: _____

Type of Organization: (check all that apply)

____Corporation ____ Nonprofit Organization

____ Partnership ____ Nonprofit-Other

____ Limited Liability Company (LLC) ____ Unincorporated Entity Other _____

Affiliate/Applicant address: _____

City: _____ State: _____ Zip: _____

Does applicant own or operate a licensed alcohol and drug health program? ___Yes ____ No

If yes, name the licensed program or facility: _____

Number of Recovery Residences operated by this organization: _____

Are you willing to fully participate in TN-ARR activities?	____Yes	____No
Have you read and understood the requirements?	____Yes	____No
Have you viewed the recovery residences standards?	____Yes	____No
Have you signed the Code of Ethics?	____Yes	____No
Has an onsite residence check been scheduled?	____Yes	____No

Section III: Contact Information

Main Contact:

Name: _____ Position/Title: _____

Phone Number: _____ Contact email: _____

Manager, senior resident or responsible person for this residence:

Name: _____ Position/Title: _____

Phone Number: _____ Contact email: _____

Residence contact information:

Name: _____ Position/Title: _____

Phone Number: _____ Contact email: _____

Section IV: Applicant Signature

I certify that this application is supported by the applicant organization named above, and that it had delegated to me the authority to submit this application on its behalf.

Print Name: _____ Date: _____

Signature: _____

Application Fee of $50 Due Upon Submission