



**Application**

If you are unable to complete this application individually please call (319) 530-4729 or (319) 351-0326 and somebody will set up a time to assist you. You may also utilize Shelter House drop-in hours Mon- Fri 1pm-4pm and Sat-Sun 8am-10am.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Current Address: \_\_\_\_\_

Cell Phone #or best way to reach you: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you currently homeless or chronically homeless?  Yes  No

Are you currently at risk of being homeless?  Yes  No If yes, please explain: \_\_\_\_\_

Do you have a photo ID?  Yes  No Do you have a Social Security Card or birth certificate?

Are you a Veteran?:  Yes  No

Are you a registered sex offender?  Yes  No

What is your current marital status? \_\_\_\_\_

Do you have kids?  Yes  No How many: \_\_\_\_\_ Who is the primary care taker \_\_\_\_\_

How were you referred to the Lodge Program? \_\_\_\_\_

**Mental Health**

Do you have a Mental Illness?  Yes  No If yes, diagnosis: \_\_\_\_\_

Have you been seen at University of Iowa Hospitals & Clinics?  Yes  No

Have you ever been hospitalized due to your mental illness?  Yes  No

If yes, where: \_\_\_\_\_ When: \_\_\_\_\_

If yes, where: \_\_\_\_\_ When: \_\_\_\_\_

If yes, where: \_\_\_\_\_ When: \_\_\_\_\_

Current treatment (list of meds with dose & frequency): \_\_\_\_\_

\_\_\_\_\_

Current Doctors or Mental Health Providers: \_\_\_\_\_

\_\_\_\_\_

List other mental health supportive programming participation: \_\_\_\_\_

**\*\*Please attach a copy of your diagnosis paperwork or notes from your last psychiatric visit.\*\***

**Physical Health**

Significant pain or illness: \_\_\_\_\_

List any physical limitations: \_\_\_\_\_

Do you have/need HIV/AIDS testing or services?  Yes  No Do you have TB:  Yes  No

Last physical: \_\_\_\_\_ Current medications: \_\_\_\_\_

\_\_\_\_\_

Would you like to see a doctor about any of the above? \_\_\_\_\_

**Substance Use History**

	Last Used When?	Frequency	Age at Onset
Alcohol:	_____	_____	_____
Marijuana:	_____	_____	_____
Cocaine:	_____	_____	_____
Meth:	_____	_____	_____
Opioids:	_____	_____	_____
Other:	_____	_____	_____

When will you be able to provide a clean/negative drug test? \_\_\_\_\_

Past Inpatient/Outpatient/IOP Substance Use Treatment (list dates, types, if completed, & where)

Date: \_\_\_\_\_ Type: \_\_\_\_\_ Completed: \_\_\_\_\_ Where? \_\_\_\_\_  
Date: \_\_\_\_\_ Type: \_\_\_\_\_ Completed: \_\_\_\_\_ Where? \_\_\_\_\_

Current Ongoing Substance Treatment

Agency: \_\_\_\_\_ Where: \_\_\_\_\_ Type: \_\_\_\_\_ Began: \_\_\_\_\_

Do you currently use tobacco products?  Yes  No

### Funding

Do you currently have health insurance  Yes  No Provider? \_\_\_\_\_

Do you currently receive benefits such as:  SSDI  SSI  Food Stamps Other Income? \_\_\_\_\_

Have you worked with vocational resources?  Yes  No

Are you in the process of applying for any resources?  Yes  No \_\_\_\_\_

### Education History

Highest school grade attended: \_\_\_\_\_ High School GED Trade College

Last school attended: \_\_\_\_\_

### Vocational History

Are you currently employed?  Yes  No Where? \_\_\_\_\_

Last Job: \_\_\_\_\_ Dates of employment: \_\_\_\_\_ To: \_\_\_\_\_

Reasons for leaving: \_\_\_\_\_

Job skills: \_\_\_\_\_

Has anything (mental health, substance abuse, etc.) interfered with your ability to work:  Yes  No If yes, please explain: \_\_\_\_\_

Is there anything else you think I should know about you? \_\_\_\_\_

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If you received assistance in completion of this form please provide their name and contact information

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Please send to 429 Southgate Ave, Iowa City, IA 52240 or fax to 319.351.3108. If there are any other questions, comments, or concerns please contact Fairweather Lodge Case Manager at 319.530.4729 or Sarah.Clutter@shelterhouseiowa.org.