

Received  
Date: \_\_\_\_\_  
Time: \_\_\_\_\_



In the provision of services to clients, ShelterCare affords equal treatment to all without regard to race, color, age, national origin, religion, sex/gender, political affiliation or belief, sexual orientation, marital status or physical or mental disability.

## The Uhlhorn Program

### PRE APPLICATION

*Please note that this is a preliminary application only. Further information and a personal interview are required before an applicant may be accepted for residency.*

### GENERAL INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Marital Status \_\_\_\_\_ Social Security Number \_\_\_\_\_

### HOUSING INFORMATION

Do you currently live:  Own apartment?  Alone?  With family/friends?  
 Adult Foster Home?  Other? Please explain: \_\_\_\_\_  
Current rent amount \$ \_\_\_\_\_ per month. Utilities' amount \$ \_\_\_\_\_ per month.  
How long have you lived in Oregon? \_\_\_\_\_  
Present landlord: Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Have you ever been evicted or asked to leave your residence?  Yes  No  
If so, why? \_\_\_\_\_

### ASSETS INFORMATION

What is your source of income?

<input type="checkbox"/> General Assistance	Amount per month	\$ _____
<input type="checkbox"/> SSI or SSDI	Amount per month	\$ _____
<input type="checkbox"/> V.A. Benefits	Amount per month	\$ _____
<input type="checkbox"/> Other	Amount per month	\$ _____

Property or other assets:  
Type \_\_\_\_\_ Value \$ \_\_\_\_\_  
Type \_\_\_\_\_ Value \$ \_\_\_\_\_

*Please answer the questions on the second page of this application.*

[uhlhorn@sheltercare.org](mailto:uhlhorn@sheltercare.org)  
[www.sheltercare.org](http://www.sheltercare.org)

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## Uhlhorn Program Application

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### ACCOMMODATION REQUESTS

- Wheelchair user                       Vision impairment  
 Balance Problems                       Hearing impairment  
 Other (Please explain)
- 
- 

### AGENCY REFERRAL

In order to determine your eligibility for our services, please furnish the names of any service agencies that may have helped you, such as vocational rehabilitation and disability services.

Agency \_\_\_\_\_ Contact \_\_\_\_\_ Phone \_\_\_\_\_

Agency \_\_\_\_\_ Contact \_\_\_\_\_ Phone \_\_\_\_\_

Agency \_\_\_\_\_ Contact \_\_\_\_\_ Phone \_\_\_\_\_

### LIVING SKILLS

Please rate your abilities in the areas listed below using the following rating scale:

- 1 Can do without assistance.
- 2 Can learn with minimal assistance.
- 3 Can learn with daily assistance.
- 4 Need ongoing assistance.
- 5 Don't know or unsure.

\_\_\_\_\_ Housekeeping                      \_\_\_\_\_ Leisure Time                      \_\_\_\_\_ Grocery Shopping

\_\_\_\_\_ Cooking and food storage    \_\_\_\_\_ Money Management                      \_\_\_\_\_ Transportation

\_\_\_\_\_ Memory Skills                      \_\_\_\_\_ Medication management                      \_\_\_\_\_ Arranging appointments

\_\_\_\_\_ Communication with others

How did you sustain your head injury? \_\_\_\_\_

\_\_\_\_\_ When? \_\_\_\_\_

*I certify, to the best of my knowledge, that the information provided here is accurate and complete.*

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

