

Transitional Housing Application

Who recommended you for this Program

☐

I am self-referred

☐

VA staff person

☐

VA outpatient clinic or Vet Center

☐

Inpatient unit at the VAMC

☐

Referred from another VA HCHV Program

☐

Non-VA staff working in a program for the homeless.

☐

Other

Please explain _____

Point of Contact Information:

Name of the person who referred you _____

Phone number of the person who referred you _____

Are you eligible to receive services at the VA? ☐ Yes ☐ No

If so, have you received services at other VA Medical Centers

If YES list please provide names below.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Support person Contact Information:

Do you have a Support Person/Family Member that you want to have involved/present during the interview?

☐ YES ☐ NO

If Yes Please Sign the Release of Information attached at the end:

Support Person:

Full Address: _____ Contact Phone #: _____

TO BE COMPLETED BY THE VETERAN WHO IS APPLYING FOR SERVICES

Veteran's Information

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

FULL Social Security# _____

Contact Phone #: _____ Cell Phone #: _____

Age/DOB: / _____

Mother's Maiden Name: _____

Whom may we contact in case of emergency? _____

Phone Number: _____

Where are you currently staying? _____

Own Home/apartment _____ Friend's Home/apartment _____

Parent's Home/apartment _____

Shelter: (name of the shelter) _____ Other _____

How much longer can you stay where you are currently living: _____

? When was the last time you lived independently? _____

What program are you applying for? **(SELECT ONE ONLY)**

- ☐ HCHV Transitional Housing
- ☐ Veterans Place
- ☐ Shepherds Heart
- ☐ Mechling-Shakley Veterans Center (268)
- ☐ Coraopolis
- ☐ Tomorrows Hope
- ☐ Helping Heroes

Military

Branch of the Service _____ Highest Rank: _____

Dates of Service: _____ To _____ Rank at discharge: _____

Type of discharge: _____ Type of job: _____

In Combat: Yes ☐ No ☐ If Yes: When? _____ Where? _____

Service Connected? ☐ YES ☐ NO

?: _____ What is your SC disability? _____

Do you currently have a claim pending for VA benefits? ☐ Yes ☐ No

Please explain:

Debt and Employment

Current amount of your monthly expenses:

How much do you owe in debt? Explain:

Current valid driver's license: ☐ Yes ☐ No What State? _____

Are you currently employed? ☐ Yes ☐ No

If yes, Where? _____ Dates: _____

What type of employment would you is interested in?

Have you ever Applied for Social Security Disability/SSI? ☐ Yes. ☐ No.

Have you ever applied for a VA Pension or NSC? ☐ Yes. ☐ No.

Do you plan on applying for Disability Benefits? ☐ Yes ☐ No If yes, Explain:

Family and Education

Marital Status: ☐ Never Married ☐ Significant Other
☐ Married ☐ Divorced
☐ Widow ☐ Separated.

If married, how many times? _____ Alimony Payments. _____

Children: Yes ☐ No ☐ How many ? _____

Visitation: Yes ☐ No ☐ Child Support Payments? (Amount) _____

Family Contact: ☐ Often ☐ Seldom ☐ Never

What Family member(s) do maintain contact with? _____

What was the last grade you Completed in school? 12

Did you graduate? ☐ Yes ☐ No GED Equivalent ☐ Yes ☐ NO

Did you attend College? ☐ Yes ☐ No

Special Training/Vocational School: _____

Medical Health History

Do you receive your Healthcare from the VA? ☐ Yes ☐ No

What Primary Care Team are you Assigned to: _____

Are you on any Prescribed Controlled Substances? ☐ Yes ☐ No What Kind: _____

Are you able to go up and down stairs? ☐ Yes ☐ No

Do you currently use a cane or walker? ☐ Yes ☐ No

Do you currently smoke or chew Tobacco ☐ Yes ☐ No

Are you or have you ever been treated for any of the following:

☐ High Blood Pressure ☐ Breathing Problems ☐ Seizures ☐ Head Injuries

☐ Diabetic ☐ Cancer ☐ Chronic Pain ☐ Back Injury ☐ Heart Attack

☐ Stroke ☐ Arthritis ☐ Ulcers ☐ Hepatitis A,B or C ☐ Other

List the Medications you are currently taking for medical reasons _____

Have you had the most recent Vaccine: Covid: ☐ Yes ☐ No Flu: ☐ Yes ☐ No

Have you ever been Hospitalized? ☐ Yes ☐ No

If Yes, When? _____

Where? _____

Why? _____

Mental Health History

Do you have any history of emotional problems or mental illness? ☐Yes ☐No

Describe your emotional/mental health issues:

Who are you currently seeing for these issues?

List the medication you are currently taking for your mental health issues:

Have you ever been in the hospital for any mental health issues? ☐Yes ☐No

If yes, Where? _____

When? _____

Reasons? _____

Family History of Mental Health treatment: ☐Yes ☐No

If yes, Who? _____

Reason(s)? _____

Have you ever attempted to take your own life or hurt yourself ? ☐ Yes ☐ No

If (Yes) When? _____

How ? _____

Assistive Technology/ Reasonable Accommodation

Do you require assistive technology? ☐Yes ☐No

If Yes, Please Explain _____

Assistive technology or adaptive technology (AT) is an umbrella term that includes assistive, adaptive, and rehabilitative devices for people with disabilities and also includes the process used in selecting, locating, and using them. AT promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing, by providing enhancements to, or changing methods of interacting with, the technology needed to accomplish Tasks.

Do you need reasonable accommodations as you participate in this program? ☐ Yes ☐ No

If YES, Please Explain _____

A **reasonable accommodation** is any modification or adjustment to a job or the work environment that will enable a qualified applicant or employee with a disability to participate in the application process or to perform essential job functions. Reasonable accommodation also includes adjustments to assure that a qualified individual with a disability has rights and privileges in employment equal to those of employees without disabilities.

Substance Abuse History

Have you or do you use or abuse Drugs or Alcohol ? ☐Yes ☐No

Do you feel that Alcohol and Drugs are a problem for you? ☐Yes ☐No

Do you Drink or use Drugs Socially? ☐Yes ☐No Recreationally? ☐Yes ☐No

Please check all that you have used/abused:

☐Alcohol ☐Marijuana ☐Cocaine/Crack ☐Heroin

☐Spice/K2 ☐Inhalants ☐Prescription Drugs ☐Other: _____

What is your drug of choice? _____

Last used Alcohol: (date)_____ Type/Amount: _____

Last used Drugs: date) _____ Type/Amount: _____

When was your last rehab? (Date)_____ Where? _____

How many rehabs have you completed? _____ When was the ~~first~~? _____

What is your longest clean/sober time? _____

Have you ever been active in a recovery program, i.e., AA, Smart Recovery,

☐Yes ☐No What Program? _____

Do you have a Sponsor? ☐Yes ☐No

Have you used other programs/agencies in the community for services? ☐Yes ☐No

Where? _____

Have you ever felt the need to bet more and more money? ☐Yes ☐No

Have you ever had to lie to people important to you about how much you gambled?

☐Yes ☐No

Legal History

Have you ever been arrested? ☐ Yes ☐ No

Convictions: _____

Do you have any court dates or outstanding warrants for your arrest? ☐ Yes ☐ No

Explain:

Are you mandated by a Court decision or sentence to meet certain requirements, such as:

☐ Probation/Parole ☐ Pay Fines/Court costs ☐ PFA (Protection from Abuse

☐ Pay Restitution ☐ Attend a Drug and Alcohol Treatment Program

☐ Give notification of your living arrangements

Give notification of your living arrangements

Other: _____

Please explain: _____

Have you ever been involved with Veterans Court? ☐ Yes ☐ No

Any history of violence toward other people? ☐ Yes ☐ No

If yes, when?

Any history of domestic violence? ☐ Yes ☐ No

Are you a Sex Offender? _____ Are you on Megan's Law? _____

Do you currently have a PFA against you or against Someone? ☐ Yes ☐ No

Are you on: ☐ Probation ☐ Parole ☐ How often are you required to report? _____

Parole/Probation Agent _____ Phone# _____

Self-Assessment

To assist staff in developing your plan of care please answers these questions:

What are your STRENGTHS? _____

What are your Limitations? _____

What are your needs? _____

What are your Barriers? _____

What are your interests? _____

Goals:

What are your Recovery Goals? _____

What are your Housing Goals? _____

What is your Income/Savings Goals? _____

Verification of Income

Please Identify all sources of Income

Source of Monthly Income	Amount
Unemployment Compensation	
SSD	
SSI	
NSC VA Pension	
SC VA Pension	
Retirement/IRA	
Welfare/Food stamps	
Child Support/Alimony	
Other	
-----	-----
Total	

**REQUEST FOR AND AUTHORIZATION TO
RELEASE HEALTH INFORMATION**

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (*Name and Address of VA Health Care Facility*)

VA Pittsburgh Healthcare System
1010 Delafield Dr
Pittsburgh, PA 15215

LAST NAME- FIRST NAME- MIDDLE NAME

DATE OF BIRTH (*mm/dd/yyyy*)

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Shepherds Heart Veteran Home; 13 Pride St, Pittsburgh, PA 15219

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☒ TREATMENT ☒ BENEFITS ☒ LEGAL ☒ EMPLOYMENT ☒ OTHER (*Please specify*) Housing

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☒ HEALTH SUMMARY (*Prior 2 Years*)

☒ INPATIENT DISCHARGE SUMMARY (*Dates*): Any information and dates relevant to current care

☒ PROGRESS NOTES:

☒ SPECIFIC CLINICS (*Name & Date Range*): Any information and dates relevant to current care

☒ SPECIFIC PROVIDERS (*Name & Date Range*): Any information and dates relevant to current care

☐ DATE RANGE: _____

☒ OPERATIVE/CLINICAL PROCEDURES (*Name & Date*): Any information and dates relevant to current care

☒ LAB RESULTS:

☒ SPECIFIC TESTS (*Name & Date*): Any information and dates relevant to current care

☐ DATE RANGE: _____

☒ RADIOLOGY REPORTS (*Name & Date*): Any information and dates relevant to current care

☒ LIST OF ACTIVE MEDICATIONS: Any information and dates relevant to current care

☒ FLU VACCINATION (*Dose, Lot Number, Date & Location*): Any information and dates relevant to current care

☒ OTHER (*Describe*): Any information and dates relevant to current care

LAST NAME- FIRST NAME- MIDDLE NAME		DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT. I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization. ☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ SICKLE CELL ANEMIA ☒ HUMAN IMMUNODEFICIENCY VIRUS (HIV) I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked <u>unless</u> I indicate by checking the box below that I do not want this information released for this specific disclosure. ☐ I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.		
AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.		
EXPIRATION: Without my express revocation, the authorization will automatically expire (select one of the following): ☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED ☐ ON (mm/dd/yyyy) _____ (enter a future date other than date signed by patient) ☒ UNDER THE FOLLOWING CONDITION(S): When discharged from all GPD programs at: Shepherd's Heart		
PATIENT SIGNATURE (Sign in ink)		DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable) (Sign in ink)		DATE (mm/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT	
FOR VA USE ONLY		
TYPE AND EXTENT OF MATERIAL RELEASED		
DATE RELEASED (mm/dd/yyyy)	RELEASED BY:	