warrior salute veteran services

Dear Applicant:

Thank you for your service to our country and for your interest in the Warrior Salute Veteran Services Program. Enclosed is a packet of information about our program and an application for services. ***Please complete the enclosed application. In addition to the completed application, the following information is needed in order for consideration of approval into Warrior Salute Veteran Services Nucor Transitional Housing program:***

REQUIRED DOCUMENTS:

- Enclosed Application (attached)
- Current Medications/Allergies
- PPD/TB test (1 year)
- DD-214 (Member-4)
- Documentation of 30 days sobriety
- Documentation of continued participating in treatment (i.e. individual and or group therapy, case management services, or community groups)

REQUESTED IF AVAILABLE:

- PTSD Screening
- TBI Screening
- Psychological Evaluation (most recent)
- Physical (1 year)
- PRI Screening
- Occupational Therapy Evaluation
- Physical Therapy Evaluation
- Neurological Evaluation
- Orthopedic Evaluation
- Social Work Evaluation
- Speech Language Pathology Evaluation
- Work Restrictions/Profile
- Drug & Alcohol Evaluation

The program will accept the most recent assessments available for the purposes of intake.

After you have gathered this information, please fax, email, or mail to:

Valarie Daniels
Nucor House Manager
Warrior Salute Veteran Services
265 Embury Road
Rochester, NY 14625
Phone: 585-314-0690
Fax: 585-364-0909
Valarie.Daniels@cdsmonarch.org

Once the application is received, it will be reviewed and you will be contacted. If you have any questions, please contact Valarie Daniels. Again, thank you for your service and for your interest in our agency.

Sincerely,
Valarie Daniels
Nucor House Manager

Mission: *Warrior Salute Veteran Services provides clinical therapies, case management and transitional housing to veterans diagnosed with post-traumatic stress disorder, traumatic brain injury and military sexual trauma so they may transition back as vital members of their communities*

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Application

REFERRAL INFORMATION

Referred by: _____ Contact # _____
Organization: _____ Fax # _____
Email: _____

VETERAN INFORMATION

Veteran's Name: _____ Phone: _____
Sex: ☐ Male ☐ Female Social Security # _____ DOB: _____
Email: _____
Current Residence: _____
Permanent Residence: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Phone Number: _____

Alternative Contact: _____ Relationship: _____
Phone Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

ARMED SERVICES HISTORY

Branch: _____ Service Dates: _____ D/C Status: _____
Deployment History: _____
Narrative Reason for Separation:
_____
_____

MEDICAL INFORMATION

☐ Traumatic Brain Injury ☐ Neurological Impairment ☐ Epilepsy (type): _____
☐ Mental Health Diagnoses: _____
☐ Medical Diagnoses: _____
☐ Physical needs (specify): _____
☐ Drug Allergies: _____
☐ Food Allergies: _____
☐ Environmental: _____
☐ OTHER: _____

Drug(s) of Choice: _____ **Last Used**: _____

SI/HI:

Suicidal Ideation: _____ Suicide Attempt: _____
Homicidal Ideation: _____ Homicidal Acts: _____

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Current Medications: *(please list all medications)*

_____ _____
_____ _____
_____ _____
_____ _____

Legal Involvement: _____

Vocational Goals: _____

Treatment Goals: _____

What are your personal goals while in the Warrior Salute Veteran Services Program?

_____
_____
_____

BENEFITS *(list amounts if applicable)*

☐ SSI ☐ SSD ☐ Public Assistance ☐ Other Wages ☐ VA Pension
☐ VA Service Connection/Disability Rating Percentage:
Other: _____

MOBILITY STATUS: (Check all that apply)

☐ Ambulatory ☐ Manual Wheelchair ☐ Able to Negotiate Stairs ☐ Power Wheelchair
☐ Other: _____

ADAPTIVE EQUIPMENT: (Check all that apply)

☐ Communication Device ☐ Wheelchair ☐ Computer ☐ Mobility Device
☐ Hearing Aid ☐ Eye Glasses ☐ Other: _____

TRANSPORTATION:

☐ Valid Driver's License ☐ Suspended License ☐ Has own vehicle ☐ No Vehicle
Insurance Information: _____

COMMUNICATION:

Primary Language: _____ Verbal: ☐ Yes ☐ No
Requires an Interpreter: ☐ Yes ☐ No Uses Sign Language: ☐ Yes ☐ No

SERVICES CURRENTLY RECEIVING:

☐ Case Management ☐ Psychiatry/Psychology ☐ Counseling ☐ Social Work
☐ OT ☐ PT ☐ Speech ☐ Nursing ☐ Other: _____

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CURRENT SERVICE PROVIDERS

Primary Care Physician: _____

Agency: _____

Address: _____ Phone #: _____

_____

Email: _____ Fax #: _____

Mental Health Professional: _____

Agency: _____

Address: _____ Phone #: _____

_____

Email: _____ Fax #: _____

Specialist (Specify): _____

Agency: _____

Address: _____ Phone #: _____

_____

Email: _____ Fax #: _____

Specialist (Specify): _____

Agency: _____

Address: _____ Phone #: _____

_____

Email: _____ Fax #: _____

Specialist (Specify): _____

Agency: _____

Address: _____ Phone #: _____

_____

Email: _____ Fax #: _____

Consent to Receive Services/Assessment

I, _____ understand that this application will be reviewed by the Warrior Salute Veteran Services Nucor Team and Medical Director, and that a clinical assessment may need to be completed to determine eligibility. I understand that if further clinical assessments need to be completed, the information regarding the assessment will be shared amongst the Warrior Salute Veteran Services Team.

Applicant Signature: _____ Date: _____

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Consent for Release of Information

Name: _____ **Last four of SS#**: _____

____ I hereby give permission to the Warrior Salute Veteran Services to receive information from:

Person (s): _____
Agency: _____
Address: _____
_____

Phone: _____ Fax: _____ E-mail: _____

____ I hereby give permission to the Warrior Salute Veteran Services to release information to:

Person (s): _____
Agency: _____
Address: _____
_____

Phone: _____ Fax: _____ E-mail: _____

I hereby give permission for information to be shared in the following format:

☐ Phone ☐ Fax ☐ Writing ☐ e-mail ☐ In person

I hereby give permission for the following information to be shared:

- ☐ Intake Assessment
- ☐ Treatment Plan
- ☐ Psych/Neurospych Evaluation
- ☐ Mental Health History
- ☐ Drug & Alcohol Evaluation
- ☐ PRI Screening
- ☐ PTSD Screening
- ☐ Medical History (including physicals, lab results and medications/allergies)
- ☐ PPD/TB test (1 year)
- ☐ OT/PT/Speech Reports
- ☐ Orthopedic Evaluation
- ☐ Social Work Evaluation
- ☐ Employment History/Evaluations
- ☐ Academic Performance
- ☐ Other (Please specify): _____

Information will be shared for the following purpose: _____

I understand that this authorization covers only the information indicated and that Warrior Salute Veteran Services will maintain the confidentiality of the information. Warrior Salute Veteran Services is prohibited from disclosure of any records it receives through use of this release. I may revoke my authorization at any time with a written request. This authorization is valid from one year from the date signed. The information obtained from the use of this release may only be used for the purpose of which it was intended. Any other use of this information is in direct violation of Confidentiality and is punishable by law.

_____

Signature Print Name Date

_____

Witness Signature Print Name Date