



# 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. We serve and support Veterans with a primary diagnosis of PTSD, TBI, Anxiety and Depression. Enclosed is a packet of information needed for 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: 585-347-4326  
[Valarie.Daniels@cdsmonarch.org](mailto: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*



# 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: \_\_\_\_\_



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Homicidal Ideation: \_\_\_\_\_

Homicidal Acts: \_\_\_\_\_

**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: \_\_\_\_\_

Requires an Interpreter:  Yes       No

Verbal:  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: \_\_\_\_\_

