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 Snyder  
Nucor House Manager  
Warrior Salute Veteran Services  
265 Embury Road  
Rochester, NY 14625  
Phone: 585-314-0690  
Fax: 585-347-4326  
valarie.snyder@cdsmonarch.org

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

Sincerely,  
Valarie Snyder  
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: ________________________
### Warrior Salute Veteran Services

<table>
<thead>
<tr>
<th>Homicidal Ideation: __________________________</th>
<th>Homicidal Acts: __________________________</th>
</tr>
</thead>
</table>

**Current Medications:** *(please list all medications)*

<table>
<thead>
<tr>
<th>Medication 1</th>
<th>Medication 2</th>
<th>Medication 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: ____________________________________________
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 #: _________________

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: _____________
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 ☐ PRI Screening ☐ Orthopedic Evaluation
☐ Treatment Plan ☐ PTSD Screening ☐ Social Work Evaluation
☐ Psych/Neurospych Evaluation ☐ Medical History (including physicals, lab results and medications/allergies)
☐ Mental Health History ☐ PPD/TB test (1 year) ☐ Employment History/Evaluations
☐ Drug & Alcohol Evaluation ☐ OT/PT/Speech Reports ☐ 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 ____________