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 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: ________________________

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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: ___________________________________ 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