# WDVA Contract Residential Services Application

**VETERAN INFORMATION**

**Veteran Name:** _____ **Date of Birth:** _____

**Full SSN:**_____/___/_____ **Veteran Phone** _____-_____-_____ **No Phone** ☐

Veteran is enrolled in the VA Puget Sound Health Care System? Yes ☐ No ☐ Unknown ☐

**Referent Information:** (You agree to be contacted on behalf of Veteran)

Staff:_____ Agency:_____

Staff phone: _____-_____-_____ email:_____

## MILITARY HISTORY

**Enlistment Date:**

_____

**Discharge Date:**

_____

**Type of Discharge:**

☐ Honorable or General (Under Honorable Conditions)

☐ Other Discharge:

_____

**Military Era:** *(check all that apply)*

☐ Vietnam ☐ Vietnam Era ☐ Peacetime

☐ Persian Gulf ☐ OIF/OEF *(9/11/2001 - present)*

**Branch of Service:**

_____

## HOUSING STATUS

**Where did the Veteran sleep last night? Outdoors (On street, in car) ☐ Shelter ☐ Hospital ☐**

**Housed-Fleeing Domestic Violence ☐ Length of time homeless in last 3 years:** _____

**Other (Explain):** _____

**Is the Veteran able to live independently and manage self-care?** YES ☐ NO ☐

(able to manage medication/hygiene/ADLs etc.) **If NO, STOP** and do not make a referral to CRS.

## Please specify Veteran's treatment needs:

(Medical/Mental Health dx, Substance Use, assistive devices, aftercare follow up etc.)

Medical Diagnoses: _____

Mental Health Diagnoses: _____

Substance Use History: _____

*CRS Orting 1301 Orting Kapowsin Hwy E Orting, WA 98360*

*Fax or email completed applications: melissa.frink@dva.wa.gov Fax: 360-893-4404*

# Request for Conviction/Criminal History Record and Consumer Reports

Name: _____
(Please Print) (First) (Middle) (Last)

Social Security Number: _____

Date of birth*: _____ Place of birth: _____ (County and State, or Country)

DL#_____ State: _____

Height*: _____ Weight*: _____ Hair color*: _____ Eye color*: _____ Race*: _____
*Used for identification only, not required.

Other names used and dates of use (including maiden name): 1. _____

2. _____ 3. _____

Have you ever been convicted of a crime? _____ Yes _____ No

If yes, give details (date, crime, location). _____

Note: Disclosure of convictions does not automatically disqualify your application.

Current address: _____
Number, Street, Apartment # (if any), City, State, Zip Code

Previous address:_____ Dates:_____
Number, Street, Apartment # (if any), City, State, Zip Code

List addresses, cities, states and counties of residence you have lived for the past seven years.

| Address | City | State | County | from | To |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Signature below authorizes and requests any present or former employer, school, police department, financial institution, division of motor vehicles, or other persons or agencies having personal knowledge about me to furnish bearer with any and all information in their possession regarding me, in connection with a tenant application. I give permission that a photocopy of this authorization be accepted with the same authority as the original.

_____ _____

Signature Date

*CRS Orting 1301 Orting Kapowsin Hwy E Orting, WA 98360*
*Fax or email completed applications: melissa.frink@dva.wa.gov Fax: 360-893-4404*

Department of Veterans Affairs

# REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

**PRIVACY ACT INFORMATION:** 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 the information including the last four of your Social Security Number (SSN) and Date of Birth (used 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 treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VHA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA" and in accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans and persons 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)*

1660 S Columbian Way
Seattle, WA 98108

| LAST NAME- FIRST NAME- MIDDLE INITIAL | LAST 4 SSN | DATE OF BIRTH |
|---|---|---|
| | | |

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

## VETERAN'S REQUEST

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

- [X] DRUG ABUSE
- [X] SICKLE CELL ANEMIA
- [X] ALCOHOLISM OR ALCOHOL ABUSE
- [X] TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

## DESCRIPTION OF INFORMATION REQUESTED

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

- [X] HEALTH SUMMARY *(Prior 2 Years)*
- [X] INPATIENT DISCHARGE SUMMARY *(Dates)*: _____
- [X] PROGRESS NOTES:
  - [X] SPECIFIC CLINICS *(Name & Date Range)*: All Clinics (All Dates)
  - [ ] SPECIFIC PROVIDERS *(Name & Date Range)*: _____
  - [ ] DATE RANGE: _____
- [ ] OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____
- [X] LAB RESULTS:
  - [ ] SPECIFIC TESTS *(Name & Date)*: _____
  - [ ] DATE RANGE: _____
- [ ] RADIOLOGY REPORTS *(Name & Date)*: _____
- [X] LIST OF ACTIVE MEDICATIONS _____
- [ ] OTHER *(Describe)*: _____

## PURPOSE(S) OR NEED

Information is to be used by the individual for:

- [X] TREATMENT
- [X] BENEFITS
- [X] LEGAL
- [X] OTHER *(Specify below)*

Housing

| LAST NAME- FIRST NAME- MIDDLE INITIAL | LAST 4 SSN | DATE OF BIRTH |
|---|---|---|
| | | |

## 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.

☐ UPON SATISFACTION OF THE NEED FOR DISCLOSURE

☐ ON _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): Discharge from the CRS Program

| 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 | RELEASED BY: |
|---|---|
| | |