WASHINGTON STATE DEPARTMENT OF VETERANS AFFAIRS

"Serving Those Who Served"

Transitional Housing Program

Admissions Checklist and Instructions

A completed Admissions Packet is required for screening and acceptance to the Transitional Housing Program (THP). The willful withholding or the intentional falsification of information during the application and/or admissions process will render the applicant disqualified from program admission. Please compile the following documents for submission.

Fax or email completed document to:

Building 10 (Retsil)
WDVA THP Case Manager, Carrie Cooke
Fax: (360) 895-4451
Email: carriec@dva.wa.gov
Cell: (360) 689-6066

Roosevelt Barracks (Orting)
WDVA THP VBS II, Delena Josephsen
Fax: (360) 893-5623
Email: Delena.Josephsen@dva.wa.gov
Cell: (253)263-0735

☐ Initial Program Application (*attached)*

To be completed by the applicant with assistance from referral source.*

☐ Request for Conviction/Criminal History Record and Consumer Reports

To be completed and signed by applicant.

Applicants who receive income from work, benefits, or any other source must provide verification of income (ex. Award letter from VA, DSHS, Social Security; Proof of retirement income (DoD).

* "Referral source" is the social worker, case manager, provider or professional.

Transitional Housing Program 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:_____

SSVF Only:
☐ Co-Enrollment
☐ Referral

MILITARY HISTORY

Enlistment Date: _____

Discharge Date: _____

Type of Discharge:

☐ Honorable or General (Under Honorable Conditions)

☐ Other Discharge: _____

Branch of Service: _____

Military Era: *(check all that apply)*

☐ Vietnam ☐ Vietnam Era ☐ Peacetime

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

Combat Experience: ☐ Yes ☐ No

If yes, explain: _____

_____

HOUSING STATUS

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

Other (Explain): _____

How many months homeless in the last 3 years? _____

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 GPD.

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: _____

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

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 Grant and Per Diem 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:

Client Release of Information and Informed Consent

IMPORTANT: Do not enter personally identifying information into HMIS for clients who are: 1) in DV agencies or; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking situation; 3) are being served in a program that requires disclosure of HIV/AIDS status (i.e.; HOPWA); or 4) under 13 with no parent or guardian available to consent to enter the minor's information in HMIS.
*If this applies to you, **STOP- Do not sign this form**.*

This agency participates in the Washington State Homeless Management Information System (HMIS) by collecting information, over time, about the characteristics and service needs of people facing homelessness. **RCW 43.185C.180 and RCW 43.185C.030**

- To provide the most effective services in moving people from homelessness to permanent housing, we need an accurate count of all people experiencing homelessness in Washington State. In order to insure that clients are not counted twice, we need to collect four pieces of personally identifying information. Specifically, we collect**: name, birth date, and race/ethnicity.** You may also choose to provide your social security number. However, signing this form does not require you to do so. Your information will be stored in our database for 7 years after the last date of service. If you have questions about collection of data or your rights regarding your personally identifying information, contact the HMIS System Administrator at: (360) 725-3028

- We use strict security policies designed to protect your privacy. Our computer system is highly secure and uses up-to-date protection features such as data encryption, passwords, and two-factor authentication required for each system user. There is a small risk of a security breach, and someone might obtain and use your information inappropriately. If you ever suspect the data in HMIS has been misused, immediately contact the HMIS System Administrator at: (360) 725-3028

- The data you provide may be combined with data from the Washington State Department of Social and Health Services (DSHS) and Education Research and Data Center for the purpose of further analysis. Your name and other identifying information will not be included in any reports or publications. Only a limited number of staff members, who have signed confidentiality agreements, will be able to see this information. Your information will not be used to determine eligibility for DSHS programs. Washington State HMIS system administrators have full access to all information in HMIS. This includes the Department of Commerce staff, designated HMIS system administrators, and the software vendor.

- By signing this form, you acknowledge and allow Department of Commerce staff to obtain additional records of information from other state agencies with which there is a data sharing agreement (DSA) on file between Commerce and the other agency. Our DSA guides data transfer and storage security protocols. If DSAs are in place, Commerce is authorized by you to obtain, add to HMIS, and use for evaluation purposes any other data you have provided to other Washington state agencies.

- Your decision to participate in the HMIS will not affect the quality or quantity of services you are eligible to receive from this agency, and will not be used to deny outreach, assistance, shelter or housing. However, if you do choose to participate, services in the region may improve if we have accurate information about homeless individuals and the services they need. Furthermore, some funders MAY require that you consent to provide your personally identifying information in HMIS in order for you to receive services from that funding source.

I understand the above statements and consent to the inclusion of personally identifying information in HMIS about me and any dependents listed below, and authorize information collected to be shared with partner agencies. I understand that my personally identifying information will not be made public and will only be used with strict confidentiality. I also understand that I may withdraw my consent at any time by filing a 'Client Revocation of Consent' form with this agency. I understand that I may obtain a copy of my signed consent form from this Agency (including forms signed electronically).

Dependent children under 18 in household, if any (Please print first and last names):

_____ _____

_____ _____

_____ _____
Client Signature (Parent/Guardian) Date

_____ _____
Client Name (Print clearly) Agency Staff Name (Print clearly) Initials

Client refused consent _____ (Agency Staff Initials) **HMIS Unique Identifier (optional) _____**