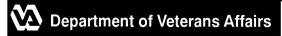
WDVA Contract Residential Services Application

Veteran Name:		Date of Birth:			
Full SSN: / /	Veteran Phone			No Phone □	
Veteran is enrolled in the VA	Puget Sound Heal	th Care System?	Yes □ No	□ Unknown □	
Referent Information: (You agree to be cor	ntacted on behalf	of Veteran)		
Staff:		Agency:			
Staff phone:		email:			
MILITARY HISTORY					
Enlistment Date:		Military Era: (ch	eck all that ap	oply)	
		□ Vietnam [□ Vietnam Er	a □ Peacetime	
Discharge Date:		☐ Persian Gulf	f □ OIF/OE	EF (9/11/2001 - present,	
Type of Discharge:		Branch of Servi	ce.		
☐ Honorable or General (Und Conditions)	der Honorable				
☐ Other Discharge:					
HOUSING STATUS					
Where did the Veteran sleep	last night? Outde	oors (On street, in	n car) □ She	elter □ Hospital □	
Housed-Fleeing Domestic Vi					
Other (Explain):					
Is the Veteran able to live (able to manage medication/hy	-				
Please specify Veteran	's treatment ne	eds:			
(Medical/Mental Health dx, S			ercare 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 Nur	mber:					
Date of birth*:		Place of birth:		(County and State, or Cou		Country)
DL#		State:				
	Weight*:tion only, not required.	Hair color*:	Eye co	lor*:	Race*:	
Other names used	and dates of use (including	maiden name): 1				
2		3				
Have you ever bee	n convicted of a crime?	Yes	No			
If yes, give details ((date, crime, location)					
Note: Disclosure o	f convictions does not auton	natically disqualify your a	pplication.			
Current address:						
Current address		artment # (if any), City, S	tate, Zip Code			
Previous address:_					Dates:	
		artment # (if any), City, S	tate, Zip Code			
List addresses, citie	es, states and counties of re	sidence you have lived for	or the past seve	n years.		
	Address	<u>City</u>	<u>State</u>	County	<u>from</u>	<u>To</u>
						
	_					
motor vehicles, or opossession regardi	uthorizes and requests any other persons or agencies had me, in connection with a ority as the original.	aving personal knowledg	e about me to fu	ırnish bearer with	n any and all inform	nation in the
			_			
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.

accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans a their records, and for other purposes authorized or required by law.	nd persons claiming	g or receiving VA benefits and			
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Address of VA Health Care Facility)					
LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH			
NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INF	ORMATION IS TO	O BE RELEASED			
VETERAN'S REQUEST					
I request and authorize Department of Veterans Affairs to release the information specified below to the request. I understand that the information to be released includes information regarding the following co		ndividual named on this			
DRUG ABUSE SICKLE CELL ANEMIA					
ALCOHOLISM OR ALCOHOL ABUSE TESTING FOR OR INFECTION WITH HUMAN IM	MUNODEFICIEN	CY VIRUS (HIV)			
DESCRIPTION OF INFORMATION REQUESTED					
Check applicable box(es) and state the extent or nature of information to be provided:					
HEALTH SUMMARY (Prior 2 Years)					
INPATIENT DISCHARGE SUMMARY (Dates):					
PROGRESS NOTES:					
SPECIFIC CLINICS (Name & Date Range):					
SPECIFIC PROVIDERS (Name & Date Range):					
DATE RANGE:					
OPERATIVE/CLINICAL PROCEDURES (Name & Date):					
LAB RESULTS:					
SPECIFIC TESTS (Name & Date):					
DATE RANGE:					
RADIOLOGY REPORTS (Name & Date):					
LIST OF ACTIVE MEDICATIONS					
OTHER (Describe):					
PURPOSE(S) OR NEED					
Information is to be used by the individual for:					
☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ OTHER (Specify below)					

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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 authorizat	ion will automatically expire.			
UPON SATISFACTION OF THE NEED F	FOR DISCLOSURE			
ON (enter a future	e date other than date signed by patient)			
UNDER THE FOLLOWING CONDITION	(S):			
<u> </u>				
PATIENT SIGNATURE (Sign in ink)			DATE (m)	n/dd/yyyy)
THE COUNTY OF TH			<i>Braz (m)</i>	
LEGAL REPRESENTATIVE SIGNATURE (if	applicable) (Sign in ink)		DATE (mi	n/dd/yyyy)
PRINT NAME OF LEGAL REPRESENTATIVE	≣	RELATIONSHIP TO PATIENT		
	FOR VA USE ONLY			
DATE RELEASED	RELEASED BY:			

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