APPLICATION COVER SHEET
MHRRTP/HOMELESS PROGRAMS
VA PITTSBURGH HCS

The VA Pittsburgh HCS Comprehensive Homeless Center offers a number of RESIDENTAL programs to assist Veterans. Following is a brief description of the services available.

Domiciliary Services

The Domiciliary Care for Homeless Veterans is a program to address the needs of homeless Veterans. Veterans are provided individual counseling and case management as well as groups focusing on sobriety maintenance, problem solving, stress management, vocational assistance and recreational activities. The goal is for Veterans to return to the work force as an independent productive individual.

Healthcare for Homeless Veterans Program

The Healthcare for Homeless Veterans (HCHV) Program provides outreach services to homeless Veterans including assessment, information, referral and case management. The HCHV Program also includes transitional and permanent housing resources. Transition housing through grant and per diem programming and supportive housing offers placements for Veterans at four scattered community sites, in rural, urban, and suburban areas. The HUD-Veterans Affairs Supportive Housing (HUD-VASH) Section 8 permanent housing program offers placement for Veterans and their family in the community. The HCHV Program offers case management for Veterans in all sites, assists in locating low cost housing in the community and acts as a liaison with Allegheny County Homeless Services providers.

CWT/TR HOUSING

The Transitional Residency Program is a work-based Psychosocial Rehabilitation Treatment Program (PRRTP) providing a rehabilitation focused community residential setting for Veterans recovering from chronic mental illness, chemical dependency and homelessness. Combining a residential, therapeutic community of peer and professional support, with a strong emphasis on increasing personal responsibility, the program helps each Veteran achieve their own personal goals toward independent living.

PRRTP HOUSING

The Psychosocial Residential Rehabilitation Treatment Program (PRRTP) is a program to address the needs of Veterans recovering from a serious mental illness (SMI). Veterans reside in a supportive environment, where they are offered a variety of services that are designed to assist them in obtaining the skills, knowledge and supports necessary to successfully transition into the community residential role of their choice.

Veterans requesting these services <u>MUST</u> complete the attached application. Upon receipt an interview will be scheduled with program staff.

Who recommended that you apply to this Program?

_____ I am self-referred

_____ VA staff person

_____ VA outpatient clinic or Vet Center

_____ Inpatient unit at the VAMC

_____ Referred from another VA HCHV Program

_____ Non-VA staff working in a program for the homeless.

_____ Other

Please explain_____

POINT of CONTACT INFORMATION:

Name of the person who referred you _____

Phone number of the person who referred you _____

Have you received services at other VA Medical Centers _____

If YES list please provide names below.

1._____2._____3._____

4._____5._____6._____

SUPPORT PERSON CONTACT INFORMATION:

Do you have a Support Person/Family Member that you want to have involved/present during the interview?
_____YES _____NO

* ***If Yes, Please sign the Release of Information attached to this application.***

Support Person:
Full Address: _____
Contact Phone #:_____

<u>*NON VA Providers</u>: Please include the following documentation with the veteran's application:

1. History and Physical
2. Psychosocial Assessment
3. Medication List
4. Release Of Information

FAX COMPLETED APPLICATION TO 412-822-1290 OR
MAIL TO:
Veterans Recovery Center
VA Pittsburgh HCS 122B-A
1010 Delafield Road
Pittsburgh, PA 15215
QUESTIONS?
CALL 412-822-1300

Application for Comprehensive Homeless Programs

VA Pittsburgh Healthcare System
1010 Delafield Road, Building 69
Phone: 412-822-1300
1-866-4VA-PITT

Veterans Recovery Center
Pittsburgh, PA 15215
FAX: 412-822-1290

Date:_____

*****TO BE COMPLETED BY THE VETERAN WHO IS APPLYING FOR SERVICES*****

Veteran's Information

LAST NAME _____FIRST NAME_____ MIDDLE NAME_____
FULL Social Security#_____
Contact Phone #: _____ Age/DOB: _____/_____
Cell Phone #: _____ Mother's Maiden Name: _____

Whom may we contact in case of emergency? _____
Phone Number: _____

Where are you currently staying?
☐ Own Home/apartment
☐ Friend's Home/apartment
☐ Parent's Home/apartment
☐ Shelter: (name of the shelter) _____
☐ Other_____

How much longer can you stay where you are currently living: _____?

When was the last time you lived independently? _____

What program are you applying for? ***(SELECT ONE ONLY)***

☐ Domiciliary
☐ HCHV Transitional Housing
  ☐ Veteran's Place
  ☐ Shepherd's Heart
  ☐ Mechling-Shakley Veterans Center (268)
  ☐ Coraopolis
☐ HUD-VASH
☐ CWT Housing
☐ SA DOM (CTAD)
☐ PRRTP-SMI

Military

Branch of the Service_____ Dates of Service: _____to_____

Highest Rank:_____ Rank at discharge:_____
Type of discharge:_____
Type of job:_____
In Combat: Yes ☐ No ☐ If Yes: When? _____ Where? _____

Service Connected
%:_____ What is your SC disability?_____

Do you currently have a claim pending for VA benefits? Yes ☐ No ☐

Please explain: _____

Debt and Employment

Current amount of your monthly expenses: _____

How much do you owe in debt?_____ Explain: _____

Current valid driver's license: Yes ☐ No ☐ What State?_____

Are you currently employed? Yes ☐ No ☐
If yes, Where?_____ Dates: _____

Longest period of employment (other than the Military): From _____ To_____

What Company did you work for during that period?_____

What was your job? _____

Reason for leaving your longest held job: ☐ Fired ☐ Laid Off ☐ Quit

Please explain your reason: _____

When was your most recent job? From_____ To_____

What Company did you work for? _____
What was your job? _____

Reason for leaving that job: ☐ Fired ☐ Laid Off ☐ Quit
Please explain your reason: _____

What type of employment would you is interested in?_____

Have you ever applied for Social Security Disability/SSI? ☐ Yes ☐ No

Have you ever applied for VA Pension or NSC? ☐ Yes ☐ No

Do you plan on applying for disability benefits? Yes ☐ No ☐ If yes, explain: _____

_____

Family and Education

Marital Status: ☐ never married ☐ significant other
☐ Married ☐ divorced
☐

☐ Widow separated

If married, how many times? _____ Alimony payments_____

Children: Yes ☐ No ☐ How many? _____

Visitation: Yes ☐ No ☐ Child Support Payments? (Amount)_____

Family Contact: ☐ Often ☐ Seldom ☐ Never

What family member(s) do you maintain contact with? _____

What was the last grade you completed in school?
1 2 3 4 5 6 7 8 9 10 11 12 +

Did you graduate? Yes ☐ No ☐ GED Equivalent Yes☐ No☐

Did you attend College? Yes ☐ No ☐

Special Training/Vocational School: _____

Medical Health History

Do you receive your healthcare from the VA? Yes☐ No ☐
What Primary Care Team are you assigned to: _____?

Who is your Primary Care Doctor: _____?

Are you or have you ever been treated for any of the following:

☐ High Blood Pressure	☐ Breathing Problems	☐ Seizures	☐ Head Injuries
☐ Diabetic	☐ Cancer	☐ Chronic Pain	☐ Back injury
☐ Heart Attack	☐ Stroke	☐ Arthritis	☐ Ulcers
☐ Hepatitis A, B, or C	☐ Other _____		

List the medication you are currently taking for medical reasons: _____
_____

Have you ever been hospitalized? Yes ☐ No ☐
If yes, When? _____
Where? _____
Why? _____

Mental Health History

Do you have any history of emotional problems or mental illness? Yes ☐ No ☐

Describe your emotional/mental health issues: _____
_____

Who are you currently seeing for these issues? _____

List the medication you are currently taking for your mental health issues: _____
_____

Have you ever been in the hospital for any mental health issues? Yes ☐ No ☐
If yes, Where? _____
When? _____
Reason(s)? _____

Family History of Mental Health treatment: Yes ☐ No ☐
If yes, Who? _____
Reason(s)? _____

SUICIDE RISK ASSESSMENT: YOU MUST ANSWER THESE QUESTIONS!

Please read each item carefully and give your best response. Over the past two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day
2. Feeling down, depressed, or hopeless
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day
3. Thoughts that you would be better off dead or hurting yourself in some way
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

Assistive Technology/Reasonable Accommodation

Do you use or require assistive technology? Yes ☐ No ☐

**If YES, please explain_____

Assistive technology or **adaptive technology (AT)** is an umbrella term that includes assistive, adaptive, and rehabilitative devices for people with disabilities and also includes the process used in selecting, locating, and using them. AT promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing, by providing enhancements to, or changing methods of interacting with, the technology needed to accomplish such tasks.

Examples of Assistive technology include, but are not limited to the curb cut in architecture, standing frames, text telephones, accessible keyboards, large print, Braille, and speech recognition software.

Do you need reasonable accommodations as you participate in this program? Yes ☐ No ☐

**If YES, please explain_____

A **reasonable accommodation** is any modification or adjustment to a job or the work environment that will enable a qualified applicant or employee with a disability to participate in the application process or to perform essential job

functions. Reasonable accommodation also includes adjustments to assure that a qualified individual with a disability has rights and privileges in employment equal to those of employees without disabilities."

Substance Abuse History

Have you or do you use or abuse drugs or alcohol? Yes ☐ No ☐

Do you feel that Alcohol and Drugs are a problem for you? Yes ☐ No ☐

Please check all that you have used/abused:

☐ Alcohol ☐ Marijuana ☐ Cocaine/Crack ☐ Heroin

☐ Spice/K2 ☐ Inhalants ☐ Prescription Drugs ☐ Other:_____

What is your drug of choice? _____

Last used Alcohol: (date) _____ Type/Amount: _____

Last used Drugs: date) _____Type/Amount: _____

When was your last rehab? (Date)_____ Where? _____

How many rehabs have you completed? _____ When was the first? _____

What is your longest clean/sober time? _____

Have you ever been active in a recovery program, i.e? AA, NA, Smart Recovery, etc...?

Yes ☐ No ☐ what program? _____

Do you have a sponsor? Yes ☐ No ☐

Have you used other programs/agencies in the community for services? Yes ☐ No ☐

Where? _____

Have you ever felt the need to bet more and more money? Yes ☐ No ☐

Have you ever had to lie to people important to you about how much you gambled? Yes ☐ No ☐

Legal History

Have you ever been arrested? Yes ☐ No ☐
Convictions: _____

Do you have any court dates or outstanding warrants for your arrest? Yes ☐ No ☐ Explain:
_____

Are you mandated by a Court decision or sentence to meet certain requirements, such as:

☐ Probation/Parole ☐ Pay fines/court costs ☐ PFA (Protection from abuse)

☐ Pay restitution ☐ Attend a drug and alcohol treatment program

☐ Give notification of your living arrangements
☐ Other: _____

Please explain: _____

Any history of violence toward other people? Yes ☐ No ☐

If yes, when? _____

Any history of domestic violence? Yes ☐ No ☐

Are you a Sex Offender? ---------- Are you on Megan's law?----------

Are you on: Probation ☐ Parole ☐ How often are you required to report? _____

Parole/Probation Agent: _____ Phone #:_____

Self-Assessment

To assist staff in developing your plan of care please answers these questions:

What are your STRENGTHS? _____

_____

What are your LIMITATIONS? _____

_____

What are your NEEDS? _____

_____

What are your ABILITIES? _____

_____

What are your INTERESTS? _____

_____

GOALS:

What are your Recovery Goals? _____

_____

What are your Housing Goals? _____

_____

What are your Employment Goals? _____

_____

Verification of Income

To be completed and signed by Dom Resident

Please identify the all sources of income.

Source of Monthly Income	Amount
Unemployment Compensation	
SSD	
SSI	
NSC VA Pension	
SC VA Pension	
Retirement/IRA	
Welfare/Food stamps	
Child Support/Alimony	
Other --- Total	---

I certify that the above information is true and correct and understand that this information is subject to verification by VA Staff. My failure to disclose all income sources or agree to

verification of income will be considered falsifying my application and may result in discharge from the program.

Print Name	Signature	Date

Please read the following and check before signing this application:

☐ *I understand and agree that providing false information on this application may result in my not being accepted or, if accepted receiving an irregular discharge from programming.*

☐ *I understand and agree that I will be required to be drug and alcohol free to gain admission into, and to continue in this Program. I understand that I must submit to a urine drug and alcohol testing at admission and randomly throughout my stay in the program.*

☐ *I understand and agree that I and/or my belongings will be searched upon admission, and at the discretion of VA Staff for illegal paraphernalia and contraband.*

☐ *I understand and agree that if accepted a medical exam will be completed on my scheduled admission date before I am admitted to ensure I am medically appropriate to participate in the program.*

☐ *I understand that surveillance cameras monitor the CWT/TR Property for the purpose of security and safety of visitors and staff.*

☐ *I understand and agree that receiving SSI, Unemployment or other disability benefits, while participating in this program, may be illegal and I accept responsibility should I chose to continue to receive these benefits.*

Veteran's Signature: _____ Date: _____

Rev 2.0, 7/20/11

(TO BE COMPLETED ONLY IF APPLYING TO DOMICILIARY RESIDENTIAL PROGRAM)*

VA Pittsburgh Healthcare System

DOMICILIARY
RESIDENTIAL VILLAS LIVING AGREEMENT

SECURITY & SAFETY

1. I agree I will **ALWAYS** exit and enter the Villa complex through the MAIN Domiciliary Building Lobby.
2. I agree I will **ALWAYS** sign in and sign out at the Lobby Desk in the MAIN Building.
3. I agree I will remain in my apartment between the hours of 11:00PM and 6:00AM unless I have staff approval to exit the building.
4. I agree I will not tamper with or interfere with any security devices or video surveillance systems in the Domiciliary buildings.
5. I agree I will not give my apartment key card to other residents or visitors and I will report immediately to staff if it is lost.
6. I agree I will not permit non-program visitors in my apartment at any time...
7. I agree I will have my visitors sign in and out at the MAIN Building Lobby Desk.
8. **I AGREE I WILL NOT SMOKE** inside any of the DOMICILIARY Buildings.
9. I agree I will not engage in any form of sexual activities with visitors, other residents or VA staff on VA property.
10. I agree to have my personal electrical devices approved by staff before using.

LIVING ARRANGEMENTS

1. I agree to keep my personal room area neat and clean at **ALL** times.
2. I agree to perform my assigned chores within my apartment to keep the living environment clean and orderly.
3. I agree to unannounced inspections of my living environment and personal effects.
4. I agree not to abuse, misuse, steal or deliberately damage VA property.
5. I agree to report to VA staff any maintenance issues in a timely manner.

As a resident of the Domiciliary Residential Villa Community I understand and agree to these program rules and I also understand violation of any of these rules WILL result in disciplinary action and possibly discharge from the program.

(SEE CODE OF CONDUCT)

_____ _____

Signature Date Staff Witness Signature Date

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction 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 Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs 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. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. 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. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial) SOCIAL SECURITY NUMBER

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):

DRUG ABUSE ALCOHOLISM OR ALCOHOL ABUSE TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

COPY OF HOSPITAL SUMMARY COPY OF OUTPATIENT TREATMENT NOTE(S) OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner'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.

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM MAY 2005 **10-5345** USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004.