VETERAN'S HAVEN NORTH

"The Rally Point"

200 SANATORIUM RD, SUITE 101 • GLEN GARDNER, NEW JERSEY 08826

908-537-1999

Medical Certification

Veteran's Haven North (VHN) is a 75 bed Grant & Per Diem (GPD) transitional housing program for homeless veterans. It is operated by the NJ Department of Military and Veteran's Affairs (DMAVA).

Please fax completed certification to 908-537-1987 or 908-537-1990 and confirm receipt with staff.

Please check one of the following:

- ☐ Admission/Annual
- ☐ Return from a Walk-in/ER Visit
- ☐ Return from a Hospital Inpatient Admission

Veteran Name: _____

Prior to VHN admission or return to VHN from inpatient hospital admissions, Veteran must meet the following criteria:

- Not observed to be in need of acute medical or psychiatric treatment
- Free of known communicable diseases
- Not in need of nursing care or skilled nursing services, i.e., able to self-administer medications, self-sufficient with wound care, if applicable
- Capable of self-evacuation to an exit and public way outside of the building, being mobile under his or her own power with or without assistive devices, without physical assistance from staff or others

Please Note: Any required medical assistance must be coordinated with outpatient or home health services. <u>There are no medical services in the program</u>.

_____ _____

Physician's or other authorized Signature * Date

_____ _____

Physician's or other authorized Printed Name Phone #

_____

License or DEA #

<u>A PERSON MUST BE LEGALLY AUTHORIZED TO ISSUE THIS CERTIFICATION, LICENSED BY THE STATE OF NEW JERSEY AS A PHYSICIAN, LICENSED ADVANCED NURSE PRACTITIONER, LICENSED CLINICAL NURSE SPECIALIST OR A LICENSED PHYSICIAN ASSISTANT</u>

Any questions regarding the criteria for the GPD program at VHN, please contact Jennifer Chrucky, Admissions Coordinator at **908-537-1980.**

Please fax completed certification to 908-537-1987 or 908-537-1990 and confirm receipt with staff.

VETERAN'S HAVEN NORTH
200 Sanatorium Rd. Suite 101, Glen Gardner, NJ 08826
Phone- (908) 537-1999 Fax- (908) 537-1990

MEDICAL RECORDS AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Veteran Name:_____ Date of Birth:_____

Phone Number:_____ Social Security #:_____

Address:_____

1. AUTHORIZATION

A. I hereby request that Veteran's Haven North provide me with:

____Mail
____Prepare for pick-up

ΔX Access to Review Originals

⌋ Photocopies of my Health Information, as requested below:

(Veteran's Haven North may provide a written summary in lieu of access to the records or photocopies, but only if I agree to this option and the related fees.)

B. I request that Veteran's Haven North release information to: **VA GPD Liaison**
Organization

151 Knollcroft Rd. Building 53 Lyons NJ _ 07939 908-647-0180
Street Address City State Zip Phone

C. Special authorizations (required to be completed before release of any records)

X_yes no I authorize release of information about drug/alcohol abuse treatment in my record.
X_yes no I authorize release of information about any mental health treatment in my record.
X_yes no I authorize release of information about my HIV status.

D. I authorize Veteran's Haven North to obtain information from: **VA GPD Liaison**
Organization

151 Knollcroft Rd. Building 53 Lyons NJ _ 07939 908-647-0180
Street Address City State Zip Phone

2. TREATMENT DATES:
(Include discharge date(s), date(s) of service, etc.)

3. DESCRIPTION OF INFORMATION TO BE RELEASED:
program participation dates and information, as well as DD214 (military record)
RECORDS FROM MY TREATMENT FORWARD TO GPD LIAISON

4. PURPOSE OF RELEASE: I authorize Veteran's Haven North to release my health information for the following specific purpose: for referral and review to the GPD liaison program at their facility

5. TERM/EXPIRATION: This signed Authorization will expire 24 months from today unless a different date or event is indicated here:

I hereby authorize Veteran's Haven North to release/disclose the health information listed above for the purposes described in this Authorization.

_____ _____
Veteran Signature/Other Authorized Person in Lieu of Veteran Signature (Explanation of authorization must be attached.) Date

_____ _____
Witness Signature Date

*******NOTICE TO RECIPIENT OF INFORMATION*******

If the Resident or their legally authorized representative authorized release of "Alcohol and Drug Abuse" information, as indicated by their initials under part 2. of this form, the following Notice applies to the information you have received pursuant to this authorization:
This information has been disclosed to you from records protected by Federal confidentiality rules 42 C.F.R. Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.