State of New Jersey
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

VETERAN'S HAVEN NORTH
"The Rally Point"
200 SANATORIUM RD, SUITE 101
GLEN GARDNER, NEW JERSEY 08826
908-537-1999

PHIL MURPHY
Governor
Commander-in-Chief

TAHESHA L. WAY
Lieutenant Governor

YVONNE L. MAYS
Brigadier General
Adjutant General

VETERAN'S HAVEN NORTH ADMISSION PACKET

Please read and follow directions below carefully. Incomplete applications may delay the admissions process.

All information can be faxed to ***Attn: Jennifer Chrucky***
Fax: 908-537-1990 / Phone: 908-537-1980
Main office: 908-537-1964
(Facility cell: 908-255-2571, alternate to main number for emergency purposes)

Referral Form (Pages 1-6)

- Do not leave any section blank. If a section does not apply, write "N/A" or "none".
- Under psychiatric treatment and substance abuse history please include diagnosis as appropriate

Medical Certification (Page 7)

- Form MUST be submitted PRIOR to admission
- PPD test MUST be completed prior to admission date
- Physician/RN MUST include license number

VHN Release of Information (Page 8)

- Fill out top with name, DOB, SSN, Phone number and address
- Sign and date at bottom where it says veteran signature

VA Release of Information (Page 9-10)

- Form must be handwritten with nothing crossed out
- Please print as clearly aspossible
- Fill in last name/first name, last 4 of SSN, and DOB near top of BOTH pages
- Sign/Date under "Patient Signature" near bottom of 2nd page

Please Include Additional Information (as appropriate)

- List of current prescribed medications
- Proof of Military Service (DD214)
- Recent medical, psychiatric, and substance abuse records including current diagnoses, medication list and progress notes

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APPLICATION FOR ADMISSION

FORWARD COMPLETED APPLICATION WITH DD214 OR OTHER STATEMENT OF MILITARY SERVICE TO:

Attn: Jennifer Chrucky Fax: 908-537-1990
Email: VHNAdmissionReferrals@dmava.nj.gov
Phone: 908-537-1980
Main office: 908-537-1964
(Facility cell: 908-255-2571, alternate to main number for emergency purposes)

I. Personal Information

1. **Name:**_____ 2. **SSN:**_____

3. **Age:** _____ **DOB:** _____

4. **Gender:** ☐ **Male /** ☐ **Female /** ☐ **Non-binary**

5. **Ethnicity/Race:**_____ 6. **Marital Status:** _____

7. **Have you beenhomeless before?** ☐ **Yes** ☐ **No** **If yes, how many times:** _____

8. **Number of Dependents:**_____**Are your dependents homeless?** ☐ **Yes** ☐ **No**

9. **Are you currently on a mortgage, deed or lease for any residential property?** ☐ **Yes** ☐ **No**

10. **Have you ever been a resident at VHN? If so when?** _____

11. **List current residence/program address:** _____

_____

12. **Please provide the name and phone number of the person assisting you with this application (if applicable):**_____

13. **Date of Discharge from program/ Eviction:** _____

14. **List phone # where you can bereached: :** _____

15. **Please list your personal e-mail address, if applicable:** _____

16. **How long have you been homeless?:** _____

Last Residence (not a Half-way House/ Program): _____

17. **Hometown/ State/County:** _____

18. **Branch of Service:** _____ **Years Served:** _____

Combat? /Where? _____

Type of Discharge: _____

Overseas Duty?/Where: _____

MOS/Job Title: _____

Reason for leaving the Military: _____

19. **Have you attached your DD214 or a Statement of Service?** ☐ **Yes** ☐ **No**

20. **Do you have healthcare insurance?** ☐ **Yes** ☐ **No**
If yes, please detail the provider:

☐ **VA Healthcare** ☐ **Medicaid** ☐ **Medicare** ☐ **Private Insurance**
☐ **Other:** _____

21. **If you aren't currently receiving VA Healthcare benefits, are you eligible?**
☐ **Yes** ☐ **No**

II. Substance Abuse Information:

1. **Do you have a history of substance abuse/dependence?** ☐ **Yes** ☐ **No**
If yes, complete this section.

2. **Drug(s) of Choice (including tobacco):** _____

Period(s) of Use: _____

3. **Last Use and Triggers:** _____

4. **List the types of substance abuse treatment program(s) you have attended:**

_____
_____
_____

III. Mental Health:

Do you have a history of mental health treatment? ☐ **Yes** ☐ **No If yes, complete this section.**

1. **List any/all psychiatric diagnosis (PTSD?):** _____
   _____
   _____
   _____

2. **List any treatment you are currently receiving (therapy/outpatient/ medications, etc.):**
   _____
   _____
   _____

3. **List any treatment you are currently receiving (therapy/outpatient/ medications, etc.):**
   _____
   _____
   _____
   _____
   _____

4. **Have you experienced any traumatic event(s) you are willing to disclose at this time?**
   _____
   _____
   _____

5. **Have you ever had thoughts of suicide?** ☐ **Yes** ☐ **No**

   Have you ever hurt yourself intentionally? ☐ **Yes** ☐ **No**

   If yes, please explain: _____

6. **Have you ever had thoughts of harming others?** ☐ **Yes** ☐ **No**

   Have you ever attempted to severely injure another? ☐ **Yes** ☐ **No**

   If yes, please explain: _____
   _____

7. **Do you currently have the desire and means to harm yourself or others?** ☐ **Yes** ☐ **No**

IV. Medical Issues

1. **List any/all medical diagnosis(es)/ physical problem(s): _____**

2. **Have you been tested for Hepatitis: _____ Results:_____**
   TB: _____ Results:_____
   HIV: _____ Results: _____

3. **Are you receiving or do you need therapy for the above listed diagnosis: ☐ Yes ☐ No**

4. **List any/all medications you are currently taking: _____**

5. **Please list any known allergies: _____**

V. Educational/Vocational History:

1. **When did you lastwork: _____**

   What kind of job wasit: _____

2. **What vocational training have you had (include dates): _____**

3. **What is your highest level ofeducation: _____**

4. **What would you want to do educationally and/or vocationally with your life: _____**

   a. **Are there any medical or other issues which would preclude you from this:_____ If yes, please list: _____**

VI. Financial/ Legal Issues:

1. **Do you have income (e.g. VA Disability, Employment, Unemployment, Social Security,etc.):_____If yes, please list amount/source: _____**

2. **Do you have an application pending for Social Security Disability or Non-Service connected Pension: _____**

3. **Do you have any financial obligations? (e.g. child support, student loans, fines, IRS, credit cards):** _____

4. **List any/all legal problems (past, present, and/or pending), include dates and outcomes, not to be limited to and including the following: arrested and convicted for a crime(s), incarcerations, court appointed restitutions, been on or are on probation and/or parole, any/all outstandingwarrants:** _____
_____
_____
_____
_____

5. **Have you ever been arrested for and convicted of assault or domestic abuse:** _____
If yes, explain (include dates andoutcome(s): _____
_____
_____

6. **Have you ever been arrested for and/or convicted under Megan's law or a similar lawagainst child molestation:**_____**If yes, explain (include dates and outcome(s):**
_____
_____

7. **Do you have a validDriver's License:**_____ **What state:**_____**Is it valid:** _____
Do you have a CDL License: __ **Issuing state:**_____**Class:**_____
Do you have a vehicle:_____ **Plans to bring one to Veteran's Haven:** _____

VI. Applicant Narrative:

1. **List some of your strong points:** _____
_____
List some of your weak points: _____
_____

2. **What do you see yourself doing in the next two years:** _____
_____

4. **What is the biggest obstacle to achieving your goals:** _____
_____

4. **Why do you want to come to Veteran's Haven:** _____
_____

5. **What do you expect from this program:** _____
_____

VII. Applicant Statement:

1. I understand that, as part of the application process, I must be agreeable to provide military and medical documentation, including, but not limited to: DD214, blood work (including pregnancy test for women), urine drug screen, and tuberculosis screening(PPD).

2. I understand I must provide Veteran's Haven North with my contact information and communicate any changes to that information, immediately, in order to facilitate my admission.

3. I understand that if I am accepted to Veteran's Haven North, I would be provided with copies of the rules/regulations and policy and procedures, which I will be expected to follow.

4. I understand that if I am accepted to Veteran's Haven North, I would work with the staff to establish and adhere to a treatment plan.

5. I understand that, as a resident at Veteran's Haven North, I would be assigned collective duty assignments/ chores related to the function and daily operation of the home.

6. I understand that I will need to sign release of information forms for healthcare providers, parole officers, etc. for coordination of my treatment plan.

7. I understand that, if I fail to answer application questions honestly and accurately, my admission and/or residency at Veteran's Haven North may beaffected.

8. I understand that, should I be accepted for residency at Veteran's Haven North, my failure to meet the aforementioned expectations may also affect my residencythere.

_____ _____

(Applicant Signature) **(Date)**

*Please note: In addition to the Application for Admission, anyone pursuing residency in the Veteran's Haven North Transitional Housing Program must also submit the following "Medical Certification for Supervised Residential Housing" form. This can be completed by any Physician of Advanced Practice Nurse who has recently evaluated and/or cared for the applicant. The forms should then be submitted to Veteran's Haven North, attention:

Jennifer Chrucky
200 Sanatorium Road, Suite 101
Glen Gardner, NJ 08826
Fax: 908-537-1990
Phone: 908-537-1980

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.

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: 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 Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is 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 the instructions, gather the necessary facts and fill out this form. 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. VA 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", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person 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)*

VA New Jersey Health Care System
385 Tremont Avenue
East Orange, NJ 07018

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 Haven North
200 Sanatorium Road
Glen Gardner, NJ 08826

PURPOSE(S) OR NEED: Information is to be used by the individual for:

☒ TREATMENT ☒ BENEFITS ☒ LEGAL ☒ EMPLOYMENT ☒ OTHER *(Please specify)* referral, screening, assessment; ongoing case management services

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: COVID TEST

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☒ RADIOLOGY REPORTS *(Name & Date)*: _____

☒ LIST OF ACTIVE MEDICATIONS: _____

☒ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☒ OTHER *(Describe)*: COVID-19 Vaccination; medical records and verification of services/eligibility (as available) required for the provision of case managementservices

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

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

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.

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

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

☒ UNDER THE FOLLOWING CONDITION(S): 30 days following discharge from Veteran's Haven North (to accommodate any follow-up).

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: