STATE OF NEW JERSEY
DEPARTMENT OF MILITARY AND VETERANS AFFAIRS
VETERANS TRANSITIONAL HOUSING PROGRAM
VETERANS HAVEN SOUTH

ADMISSIONS REFERRAL APPLICATION FORM

Referring Agency:_____ Referral Date:_____

Referral Source Contact: _____

Title:_____

Contact Number:_____

Veterans Information

Veteran's Name:_____ Veteran's phone number: _____

DOB:_____ Social Security Number:_____

Branch of Service/Rank:_____

Income (source/monthly amount): _____

Current living situation: _____

Discharge/eviction date: _____

Does Veteran have health care insurance? Yes / No If yes, please detail the provider:

_____

History of substance use disorder Yes / No

Any criminal charges/convictions Yes/No List description of charge and date: _____

_____

Drug(s) of choice_____date of last use:_____

Currently receiving medicated assisted treatment: Yes / No (Methadone, Suboxone, Vivitrol, Naltrexone, other)_____

If yes, has future treatment been arranged? Where? Appt date/time: _____

Mental health diagnosis: Yes / No

List diagnosis:

_____

Thoughts of suicide/suicide attempts: yes / no date:_____

Hospitalizations: _____

Medical diagnosis list:

_____

_____

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Items to be included with referral form:

_____Medication List

_____PPD results (within 6 months)

_____Medical Certification (DCA requirement)

_____Mental Health Evaluation (Current)

_____Physical Evaluation (Current)

PLEASE FORWARD TO ADMISSIONS DEPARTMENT VIA:

- EMAIL: VHSAdmissions@dmava.nj.gov

Any Questions Call: 609-561-4990

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Applicants considered for acceptance at the Veterans Transitional Housing Program Veterans Haven South) Must:

- Be A Veteran eligible for GPD through the VA.
- Veteran must be committed to remaining drug and alcohol free.
- Have either a reliable source of income or be a candidate to establish reliable income through employment and/or disability applications.
- Not have ***any*** pending charges or convictions for sexual offenses.
- Have recent TB Test within six months of application date.
- Be able to complete all Activities of Daily Living (ADL); manage own medications, mobility, dressing, showering, maintain room cleanliness.
- Be willing/able to participate in assignment of chores.
- Be medically and psychologically stable. (Evaluations with 14 days of application date)
- Be willing to comply with all Veterans Haven rules and regulations.
- Be willing to provide financial status and history to case manager *monthly* and pay rent as calculated.
- Satisfactorily complete the interview process in person or via Skype.
- Be registered with the Corporal Michael J. Crescenz VA Medical Center.
- Sign Release of Information (ROI) between Veterans Haven, VA Medical, and any non-VA medical providers.
- Have *NO* outstanding warrants. (If on Parole/Probation; must have written permission prior to admission)

I, _____meet and agree to all the above list admission criteria for Veterans Haven South. I agree to fully participate in their program and follow all program rules and requirements.

_____	_____	_____
Print Name	Veterans Signature	Date

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Appendix C

MEDICAL CERTIFICATION
FOR
SUPERVISED RESIDENTIAL HOUSING

THIS MEDICAL CERTIFICATION IS TO CERTIFY THAT:

_____

RESIDENT NAME

WAS EXAMINED BY ME AND FOUND TO BE FREE FROM EVIDENCE OF COMMUNICABLE DISEASES AND

THIS PERSON CAN LIVE INDEPENDENTLY AND IS NOT IN NEED OF ASSISTANT LIVING OR NURSING CARE AND

THIS PERSON IS 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 ASSISTANCE DEVICES, WITHOUT THE PHYSICAL ASSISTANCE OF STAFF OR OTHERS AND

THIS PERSON IS CAPABLE OF SELF-ADMINISTERING MEDICATIONS WITHOUT SUPERVISION.

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Physician's or authorized Signature Date
License of DEA #:

Signature must include at least the first initial and full surname and title of a person, not a group or hospital, legibly written with his or her own hand.

INITIAL CERTIFICATION MUST BE COMPLETED PRIOR TO FINAL ADMISSION APPROVAL. SUBSEQUENT CERTIFICATIONS REQUIRED ANNUALLY. A PERSON MUST BE LEGALLY AUTHORIZED TO ISSUE THIS CERTIFICATION, LICENSED BY THE STATE OF NJ OR PA AS A PHYSICIAN OR AS A LICENSED ADVANCED NURSE PRACTITIONER OR AS A LICENSED CLINICAL NURSE SPECIALIST OR A LICENSED PHYSICIAN ASSISTANT.

Updated 15 February 2021

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK 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 information needed 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 the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 24VA10A7 "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 Location of the VA Health Care Facility)*

Philadelphia VA Medical Center
3900 Woodland Avenue
Philadelphia, PA 19104

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Veterans Haven South
301 Spring Garden Road, P.O. Box 80 Winslow, NJ 08095

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

☒ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☒ OTHER *(Please specify below):*

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☒ HEALTH SUMMARY *(Prior 2 Years)*

☒ PATIENT MEDICAL RECORDS *(Dates)*:

☒ 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:

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

☒ ADMINISTRATIVE RECORDS:

☒ OTHER *(Describe)*: any and all physical and/or mental health information requested

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

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 *(select one of the following)*:

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

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): Effective from the date of application and will remain in effect until 7 days past discharge date or 364 days from date of this release.

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 *(mm/dd/yyyy)*	RELEASED BY: