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

PHIL MURPHY
Governor
Commander-in-Chief

JEMAL J. BEALE
Brigadier General
The Adjutant General

APPLICATION FOR ADMISSION

FORWARD COMPLETED APPLICATION
WITH DD214 OR OTHER STATEMENT OF MILITARY SERVICE TO:
Attn: Jennifer Chrucky
Phone: 908-537-1999 Ext: 1980
Fax: 908-537-1990
Email: Jennifer.Chrucky@dmava.nj.gov

I. Personal Information:

1. **Name:**_____ 2. **SSN:** _____
3. **Age:**_____ **DOB:** _____
4. **Ethnicity/Race:**_____ 5. **Marital Status:** _____
6. **Have you been homeless before?** ☐ **Yes** ☐ **No**
   If yes, how many times: _____
   Number of Dependents:_____ **Are your dependents homeless?** ☐ **Yes** ☐ **No**
7. **Have you ever been a resident at VHN? If so when?** _____
8. **List current residence/program address:** _____
   _____
9. **Please provide the name and phone number of the person assisting you with this application (if applicable:** _____
10. **Date of Discharge from program/ Eviction:** _____
11. **List phone # where you can be reached:** _____

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

13. How long have you been homeless? : _____

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

14. Home Town/ State/County: _____

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

Combat? /Where? _____

Type of Discharge: _____

Overseas Duty? /Where: _____

MOS/Job Title: _____

Reason for leaving the Military: _____

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

17. Do you have health care insurance? ☐ **Yes** ☐ **No**
If yes, please detail the provider:

☐ **VA Healthcare** ☐ **Medicaid** ☐ **Medicare** ☐ **Private Insurance**

☐ **Other:** _____

18. If you aren't currently receiving VA Healthcare benefits, are you eligible for them?

☐ **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 last work: _____

What kind of job was it: _____

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

_____

_____

3. What is your highest level of education: _____

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 outstanding warrants:** _____
_____
_____
_____
_____

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

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

7. **Do you have a valid Driver'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 myadmission.

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 tofollow.

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 treatmentplan.

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

MEDICAL CERTIFICATION
FOR
SUPERVISED RESIDENTIAL HOUSING

FOR A PERSON THAT **DOES NOT** REQUIRE SKILLED NURSING SERVICES

FOR A PERSON **WHO 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 ASSISTIVE DEVICES, **WITHOUT** THE PHYSICAL ASSISTANCE OF STAFF OR OTHERS

THIS MEDICAL CERTIFICATION IS TO CERTIFY THAT:

_____

RESIDENT NAME

WAS EXAMINED BY ME AND FOUND TO BE **FREE FROM EVIDENCE OF COMMUNICABLE DISEASES** AND **NOT IN NEED OF NURSING CARE.**

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 ASSISTIVE DEVICES, **WITHOUT** PHYSICAL ASSISTANCE FROM STAFF OR OTHERS.

THIS PERSON DOES NOT REQUIRE SERVICES THAT EXCEEDS THE LEVEL OF CARE PROVIDED BY THE STATE REGULATED SUPERVISED RESIDENTIAL HOUSING FACILITY.

---------- ----------

Physician's or authorized Signature * **Date**
License or DEA #

DCA Revised 5/16/11

- **Signature must include at least the first initial and full surname and title (for example MD or RN.)**
- **of a person, not a group or hospital, legibly written with his or her own hand.**
- **LICENSE NUMBER ISSUED BY STATE OF NEW JERSEY MUST BE INCLUDED**

INITIAL CERTIFICATION MUST BE COMPLETED PRIOR TO ADMISSION, SUBSEQUENT CERTIFICATIONS YEARLY

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

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):
VANJHCS
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 #101
Glen Gardner, NJ 08826

PURPOSE(S) OR NEED: Information is to be used by the organization or 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:
- ☐ Specific tests (name & date):
- ☐ Date range:

☐ Radiology Reports (name & date):
☒ List of Active Medications
☐ Flu Vaccination (dose, lot number, date & location)
☒ Other (describe below): medical records and verification of services/eligibility (as available) required for the provision of case management services

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 the 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, or because a condition of VA employment mandates the signing of this authorization. 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 information disclosed per this authorization may no longer be protected by Federal confidentiality laws or regulations and may be subject to re-disclosure by the recipient.

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): upon discharge and through the discharge process from the VA Grant and Per Diem Program

PATIENT SIGNATURE	DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable)	**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: