Harvest House
Transitional Centers

FREEDOM SUBSTANCE ABUSE TREATMENT
VA GRANT & PER DIEM
APPLICATION/REQUIREMENTS for ADMISSION

PURPOSE: Our primary goal is to facilitate a stable environment that gives Veterans an opportunity to break the cycle of homelessness and addiction as they rebuild their lives and re-enter society as an active contributing member by achieving residential stability, increasing their skill level, and obtaining greater understanding of their strengths and purpose.

PROGRAM: Harvest House provides an opportunity for a new life conforming to right moral standards in a home-like, faith-based environment.

COST: Per Diem funds cover cost of housing, treatment, basic food items, and access to public transportation.

ACCOUNTABILITY: Residents develop a character of respect, integrity, and humility as they honor the program structure of Harvest House; i.e. *Progressive Four Phase Program, Daily Schedule, House Rules, Cause for Disciplinary Discharge, etc.* as well as staff directives.

GUIDELINES:

A. Commit to nine months of residency with the goals of independent & sober living.
B. Honor House Rules and staff directives with diligence and respect.
C. Break from dysfunctional people, places, and things that brought you to Harvest House.
D. Agree to a search of your person and possessions upon arrival, or at anytime thereafter, while a resident of Harvest House. Agree to random urinalysis and upon request.
E. Resident will set up escrow account with the purpose of saving towards independent living.
F. Harvest House reserves the right to discharge any resident at anytime for not complying with the Code of Conduct or Program Description. If discharged, agree to leave without disruption to staff or other residents.

If you share the perspective offered by Harvest House, you are welcome to make official application for admission by signing below. Your signature denotes that you have voluntarily and free of coercion, read and agree to submit to the authority of Harvest House as referenced in this document. Upon the review of your completed application and the available bed space you will be notified as to acceptance. To contact HHTC call (941) 953-3154.

Please remember to enclose the proper release form from your contact person (lawyer, case worker, probation officer, Chaplain, counselor, family member, friend, other).

Applicant's Name (PRINT):_____

Applicant's Signature:_____ Date:_____

Anticipated Admission Date:_____ Time:_____

Staff Approval:_____ Date:_____

IDENTIFICATION INFORMATION

Date:_____

First Name:_____ Last Name:_____ M.I.:_____

Currently Homeless: Y N If No, Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

SS#:_____ Sex:_____ Citizenship:_____

Age:_____ D.O.B.:_____ Marital Status:_____ Race:_____

Living with:_____ Relationship:_____

Spouses Name:_____ Address:_____

No. of Children:_____ Are you a veteran?_____

Level of Education:_____

Do you have a FL I.D./D.L.: Y N Birth Certificate: Y N SS Card: Y N

What languages do you speak?:_____

Give a one word description of your life now:_____

FINANCIAL ASSISTANCE

Please circle the following financial assistance you are currently receiving and the amount per month:

SSI $_____.____ Other? _____ $_____.____

SSDI $_____.____

Food Stamps $_____.____

WIC $_____.____

HUD $_____.____

Cash Assistance $_____.____

If you are unable to pay your program fee who will be your guarantor to insure that it is paid?_____

_____

PREVIOUS COUNSELING HISTORY

Have you ever gone for counseling?:_____ When?:_____

Where?:_____

For what?:_____

Are you currently receiving help from another professional?:_____ Who?:_____

Have you ever attempted suicide?:_____ Has anyone in your family?:_____

Has anyone in your family ever been diagnosed mentally ill?:_____

CRIMINAL JUSTICE SYSTEM

Charges Pending:_____

City:_____ Judge:_____ Next hearing date:_____

Are you n Probation or Parole? (circle one) Date of Sentencing:_____

Probation Officer:_____ Phone No. of PO:_____

Address of PO:_____

Terms of Probation/Parole:_____

Ever violated?:_____ When?:_____

Prior Criminal History:

Date	City	Charge	Disposition

Attorney/Public Defender's Name:_____

Address:_____

Appointed or Retained (circle one)_____

Have you ever been required to register as a sex offender?_____

If yes, when was it and what were the charges? (use space provided below)

SUBSTANCE ABUSE HISTORY

Check all that you have abused and when:

DRUG	USED		HOW OFTEN	HOW LONG
	Past	Present	Frequency	Duration
Alcohol	____	_____	_____	_____
Marijuana	____	_____	_____	_____
Hallucinogenic	____	_____	_____	_____
Barbiturates	____	_____	_____	_____
Amphetamine	____	_____	_____	_____
Methamphetamine	____	_____	_____	_____
Heroin	____	_____	_____	_____
Methadone	____	_____	_____	_____
Cocaine	____	_____	_____	_____
Opiates	____	_____	_____	_____
K2/Spice	____	_____	_____	_____
Other?_____	____	_____	_____	_____

Have you used alcohol in the last 7 days?:_____ When?:_____

Is alcohol your drug of choice?:_____

Have you used a drug in the last 7 days?:_____ What?:_____ When?:_____

What is your drug of choice (excluding alcohol)?:_____

QUESTIONS:

Do you feel alcohol/drugs are a problem for you?	Y	N
Have you ever been arrested under the influence/high?	Y	N
Have you ever needed more alcohol/drugs to get the same affect?	Y	N
Has anyone ever complained about your behavior?	Y	N
How old were you when you first noticed your problem?	_____	
Have you ever tried to cut down or stop using alcohol/drugs?	Y	N

When?:_____

EMPLOYMENT HISTORY

Are you currently employed?_____ If yes, where?:_____

Position/Title:_____ Name/Number of Supervisor:_____

LIST YOUR 3 MOST RECENT JOBS:

Employer	Position	Time Frame (dates)	Reason for leaving	Attitude toward job

What kind of work are trained to do?:_____

What kind of work are you interested in?:_____

YOUR HEALTH AND MEDICAL INFORMATION

Doctor's Name: _____
Doctor's Address: _____
Doctor's Phone #: _____
Medical Insurance: Yes or No Policy #: _____

When did you last see a Doctor? _____ For What? _____
Have you ever used needles? _____
Have you had an HIV test? _____ When? _____/_____/_____ Result?:_____

Have you had any other S.T.D. tests? _____ When? ____/____/____ Result?:_____
Treatment history? _____

Is it possible that you are pregnant?:_____

Have you taken any medication in the last year? _____

What: _____ When: _____

** Please list all medication you are currently taking:

_____

_____

Are you on a special diet? _____ If so, what?_____

Please list any current allergies or physical complaints/problems:_____

_____

_____

Check symptoms you **currently** have:

_____Allergies	_____Dizziness	_____Upset stomach
_____Asthma	_____Insomnia	_____Bleeding
_____Mental Illness	_____Digestive problems	_____Excess fatigue
_____Chronic cough	_____DT's	_____Depression
_____Dermatitis	_____Rapid weight loss	_____Epilepsy
_____Dental problems	_____VD or Herpes	_____Back problems
_____Diarrhea	_____HIV (AIDS)	_____Hearing loss
_____High blood pressure	_____Liver problems	_____Hepatitis
_____Difficulty breathing	_____Tuberculosis	_____Heart disease
_____Open sores	_____Bone or joint pain	_____Vision problems
_____Constipation	_____Chest pain	_____other

Explain above symptoms:

_____

_____

_____

Have you ever been diagnosed with a mental illness? _____ What? _____

When? _____ What medication was prescribed? _____

How did you hear of Harvest House Transitional Centers?_____

List 3 goals you hope to achieve by participating in this program:

1)_____

2)_____

3)_____

Additional Notes:

It is a requirement for applicants to complete the following VA Release Medical Information form in order to determine eligibility

All questions and sections must be completed for this application to be processed. Please return your application Admissions at 209 N Lime Ave Sarasota, FL 34237, via fax (941) 954-2349, scan & email to info@harvesthousecenters.com, or in person.

Thank you for your interest in our program. Your application will be processed within 48 hours from the time we receive it. If you do not here from our Admissions department regarding your application please feel free to contact us.

"Your Freedom Starts Now"

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)

Bay Pines VAMC - 10000 Bay Pines Blvd.
Bay Pines, FL 33744

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

Harvest House Grant Per Diem 2100 Mango Avenue, Sarasota, FL. 34237

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)

mental and physical health care records/noes from computerized patient record system

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

Harvest House Grant Per Diem program to determine eligibility, appropriateness and or level of care, functioning and ability to live independently; to assess on-going mental/physical health care

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):

This release is effective from the date signed by patient and expires one (1) year from this signed date.

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