Harvest House

V.E.T.S. - Veterans Empowered through
Transitional Services
GRANT & PER DIEM PROGRAM

Application 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.

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

GUIDELINES:

A. Commit to working with case manager to set and achieve goals in preparation for independent living.
B. Honor program guidelines and staff directives with diligence and respect.
C. Agree to a search of your person and possessions upon arrival, and while a resident of Harvest House. Agree to random urinalysis and upon request.

You are welcome to make official application for admission by completing the following application and signing below. Upon the review of your completed application and the available bed space you will be notified as to acceptance. All questions and sections must be completed for this application to be processed. Please return your application to Admissions via mail to 3650 17th Street, Sarasota, FL 34235, via fax (941) 954-2349, scan & email to info@harvesthousecenters.com, or in person.

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

Today's 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.:_____ Place of birth:_____

Marital Status:_____ Race:_____

Living with:_____ Relationship:_____

Spouses Name:_____ Address:_____

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

Level of Education:_____ If yes, branch & years of service:_____

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, including out of county and state charges:

Date of Charge	City, State	Charge Type	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?:_____		

MENTAL HEALTH HISTORY

Have you ever been diagnosed with a mental illness? _____ If so, what was the diagnosis? _____
_____

When was the diagnosis? _____ Who made the diagnosis?_____

What medication was prescribed? _____

What medication are you currently taking for diagnosis?_____

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?:_____

HOUSING HISTORY

Where did you sleep last night (i.e. outside, friend's couch, your own apartment, shelter)?

_____

How long have you been sleeping there?_____

How many times have you experienced homelessness in the last 3 years?_____

When was the last time you had a safe, permanent place to live?_____

How long did you live there?_____

HEALTH AND MEDICAL INFORMATION

Doctor's Name: _____ 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?:_____ Are you <u>currently</u> taking medication? _____

**List medications you are currently taking: _____

_____

_____

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

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:

_____

_____

Are you capable of carrying out activities of daily living without assistance (i.e. caring for your personal needs, such as preparing meals, cleaning living space, personal hygiene)?_____

If no, please explain:_____

_____

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

_____

_____

How did you hear of Harvest House?_____

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

1)_____

2)_____

3)_____

<u>Additional notes you'd like Harvest House to know:</u>

<u>*It is a requirement for applicants to complete the following VA Release Medical Information form in order to determine eligibility***</u>**

Thank you for your interest in our program. <u>All questions and sections must be completed for this application to be processed</u>. Please return your application to Admissions at 3650 17th Street, Sarasota, FL 34235, via fax (941) 954-2349, scan & email to info@harvesthousecenters.com, or in person.

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):
C.W. Bill Young VAMC
10,000 Bay Pines Blvd.
Bay Pines FL. 33744

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
Harvest House
2100 Mango Ave. Sarasota, FL. 34234

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

☐ Treatment ☐ Benefits ☐ Legal ☐ Employment ☐ Other – Please specify._____

_____

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): Veral communication of Veteran's health information to ficilitate treatment and address housing needs

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):_____

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: