



"Serving Those Who Served"

Transitional Housing Program

Admissions Checklist and Instructions

A completed Admissions Packet is required for screening and acceptance to the Transitional Housing Program (THP). The willful withholding or the intentional falsification of information during the application and/or admissions process will render the applicant disqualified from program admission. Please compile the following documents for submission.

Email or fax completed document to:

Building 10 THP (Retsil)

WDVA THP VBS II, William Brown

Fax: (360) 895-4451

Email: William.Brown@dva.wa.gov

Cell: (360) 764-0727

THP Orting

WDVA THP VBS II, Trent Mortensen

Fax: (360) 893-4404

Email: Trent.Mortensen@dva.wa.gov

Cell: (360)982-4830

- Initial Program Application (*attached*)
To be completed with assistance from referring social worker, case manager, or provider
- Request for Conviction/Criminal History Record and Consumer Reports
*To be completed and signed by applicant. **All highlighted areas must be filled out completely.***
- Is the Veteran requesting same day entry? Applies to CERS Only.***
Veteran must have an active housing plan, able to obtain housing within 60 days, and eligible for VA Healthcare.
- VA & HMIS ROIS
- ADL Verification Form

Transitional Housing Program Application

VETERAN INFORMATION

Veteran Name: _____ Date of Birth: _____

Full SSN: ____/____/____ Veteran Phone _____ No Phone

Veteran is enrolled in the VA Puget Sound Health Care System? Yes No Unknown

Veteran Identifies as: Male Female Other: _____

Referent Information: (You agree to be contacted on behalf of Veteran)

Staff: _____ Agency: _____

Staff phone: _____ Email: _____

SSVF Only:

Co-Enrollment

Referral

MILITARY HISTORY

Enlistment Date: _____

Military Era: (check all that apply)

Discharge Date: _____

Vietnam Vietnam Era Peacetime

Type of Discharge:

Persian Gulf OIF/OEF (9/11/2001 - present)

Honorable or General (Under Honorable Conditions)

Combat Experience: Yes No

Other Discharge: _____

If yes, explain: _____

Branch of Service: _____

HOUSING STATUS

Where did the Veteran sleep last night? Outdoors (On street, in car) Shelter Hospital Fleeing DV

Other (Explain): _____

How many months homeless in the last 3 years? _____

Does Veteran have: VASH enrollment SSVF enrollment High Income

Other Current Housing Plan: _____

Is Veteran able to enter within 24 hours if eligible and space is available? Yes No

Is the Veteran able to live independently and manage self-care? YES NO

(able to manage medication/hygiene/ADLs etc.) If NO, STOP and do not make a referral to GPD.

Please specify Veteran's treatment needs:

(Medical/Mental Health dx, Substance Use, assistive devices, aftercare follow up etc.)

Medical Diagnoses: _____

Mental Health Diagnoses: _____

Substance Use History: _____

Request for Conviction/Criminal History Record and Consumer Reports

Name: _____
(Please Print) (First) (Middle) (Last)

Social Security Number: _____

Date of birth*: _____ Place of birth: _____ (County and State, or Country)

DL# _____ State: _____

Height*: _____ Weight*: _____ Hair color*: _____ Eye color*: _____ Race*: _____

*Used for identification only, not required.

Other names used and dates of use (including maiden name): 1. _____

2. _____ 3. _____

Have you ever been convicted of a crime? ___ Yes ___ No

If yes, give details (date, crime, location). _____

Note: Disclosure of convictions does not automatically disqualify your application.

Current address: _____
Number, Street, Apartment # (if any), City, State, Zip Code

Previous address: _____ Dates: _____
Number, Street, Apartment # (if any), City, State, Zip Code

List addresses, cities, states and counties of residence you have lived in for the **past seven years.**

<u>Address</u>	<u>City</u>	<u>State</u>	<u>Zip Code</u>	<u>From</u>	<u>To</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Signature below authorizes and requests any present or former employer, school, police department, financial institution, division of motor vehicles, or other persons or agencies having personal knowledge about me to furnish bearer with any and all information in their possession regarding me, in connection with a tenant application. I give permission that a photocopy of this authorization be accepted with the same authority as the original.

Signature

Date



REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

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)

VA Puget Sound Healthcare System
1660 S Columbian Way 9600 Veterans DR SW
Seattle, WA 98108 Lakewood, WA 98498

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

Washington State Department of Veterans Affairs Transitional Housing Program in Orting, WA and Port Orchard, WA

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

[X] TREATMENT [X] BENEFITS [X] LEGAL [X] EMPLOYMENT [X] OTHER (Please specify below):

All matters pertaining to housing needs

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

- [X] HEALTH SUMMARY (Prior 2 Years)
[X] PATIENT MEDICAL RECORDS (Dates):
[X] INPATIENT DISCHARGE SUMMARY (Dates):
[X] PROGRESS NOTES:
[X] SPECIFIC CLINICS (Name & Date Range): All clinics all dates
[] SPECIFIC PROVIDERS (Name & Date Range):
[] DATE RANGE:
[] OPERATIVE/CLINICAL PROCEDURES (Name & Date):
[X] LAB RESULTS:
[] SPECIFIC TESTS (Name & Date):
[] DATE RANGE:
[] RADIOLOGY REPORTS (Name & Date):
[X] LIST OF ACTIVE MEDICATIONS:
[] VACCINATION (Dose, Lot Number, Date & Location):
[] ADMINISTRATIVE RECORDS:
[X] OTHER (Describe): All matters pertaining to housing needs

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. <input checked="" type="checkbox"/> DRUG ABUSE <input checked="" type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE <input checked="" type="checkbox"/> SICKLE CELL ANEMIA <input checked="" type="checkbox"/> 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 <u>unless</u> I indicate by checking the box below that I do not want this information released for this specific disclosure. <input type="checkbox"/> 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): <input type="checkbox"/> AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED <input type="checkbox"/> ON (mm/dd/yyyy) _____ (enter a future date other than date signed by patient) <input checked="" type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): <u>Discharge from the Grant and Per Diem or Contract Residential Services program</u>		
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:	

Client Release of Information and Informed Consent

IMPORTANT: Do not enter personally identifying information into HMIS for clients who are: 1) in DV agencies or; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking situation; 3) are being served in a program that requires disclosure of HIV/AIDS status (i.e.; HOPWA); or 4) under 13 with no parent or guardian available to consent to enter the minor’s information in HMIS.

*If this applies to you, **STOP- Do not sign this form.***

This agency participates in the Washington State Homeless Management Information System (HMIS) by collecting information, over time, about the characteristics and service needs of people facing homelessness. **RCW 43.185C.180 and RCW 43.185C.030**

- To provide the most effective services in moving people from homelessness to permanent housing, we need an accurate count of all people experiencing homelessness in Washington State. In order to insure that clients are not counted twice, we need to collect four pieces of personally identifying information. Specifically, we collect: **name, birth date, and race/ethnicity.** You may also choose to provide your social security number. However, signing this form does not require you to do so. Your information will be stored in our database for 7 years after the last date of service. If you have questions about collection of data or your rights regarding your personally identifying information, contact the HMIS System Administrator at: (360) 725-3028
- We use strict security policies designed to protect your privacy. Our computer system is highly secure and uses up-to-date protection features such as data encryption, passwords, and two-factor authentication required for each system user. There is a small risk of a security breach, and someone might obtain and use your information inappropriately. If you ever suspect the data in HMIS has been misused, immediately contact the HMIS System Administrator at: (360) 725-3028
- The data you provide may be combined with data from the Washington State Department of Social and Health Services (DSHS) and Education Research and Data Center for the purpose of further analysis. Your name and other identifying information will not be included in any reports or publications. Only a limited number of staff members, who have signed confidentiality agreements, will be able to see this information. Your information will not be used to determine eligibility for DSHS programs. Washington State HMIS system administrators have full access to all information in HMIS. This includes the Department of Commerce staff, designated HMIS system administrators, and the software vendor.
- By signing this form, you acknowledge and allow Department of Commerce staff to obtain additional records of information from other state agencies with which there is a data sharing agreement (DSA) on file between Commerce and the other agency. Our DSA guides data transfer and storage security protocols. If DSAs are in place, Commerce is authorized by you to obtain, add to HMIS, and use for evaluation purposes any other data you have provided to other Washington state agencies.
- Your decision to participate in the HMIS will not affect the quality or quantity of services you are eligible to receive from this agency, and will not be used to deny outreach, assistance, shelter or housing. However, if you do choose to participate, services in the region may improve if we have accurate information about homeless individuals and the services they need. Furthermore, some funders MAY require that you consent to provide your personally identifying information in HMIS in order for you to receive services from that funding source.

I understand the above statements and consent to the inclusion of personally identifying information in HMIS about me and any dependents listed below, and authorize information collected to be shared with partner agencies. I understand that my personally identifying information will not be made public and will only be used with strict confidentiality. I also understand that I may withdraw my consent at any time by filing a ‘Client Revocation of Consent’ form with this agency. I understand that I may obtain a copy of my signed consent form from this Agency (including forms signed electronically).

Dependent children under 18 in household, if any (Please print first and last names):

_____	_____
_____	_____

Client Signature (Parent/Guardian)

Date

Client Name (Print clearly)

Agency Staff Name (Print clearly) Initials

Client refused consent _____ (Agency Staff Initials)

HMIS Unique Identifier (optional) _____



Activities of Daily Living Requirement

Veteran Name: _____

Activities of daily living (ADLs) are routine activities people do every day without assistance. The basic ADLs that you must be able to do independently and consistently to stay in WDVA Transitional Housing are:

- Daily bathing and hygiene
- Dressing
- Eating
- Using the restroom
- Able to move independently
- Able to go short distances (ex: public bathrooms, mess hall)
- Manages own medications
- Able to clean personal space

PLEASE NOTE: *If you are unable to do even one of the ADLs listed above, WDVA Transitional Housing will not be a suitable environment to meet your needs.*

I have read or have had explained to me the ADL requirements for entering WDVA Transitional Housing and agree that I am able to perform them without assistance.

Signature

Date