11400 Irvine Road, Winchester, Kentucky 40391

Phone: 859-806-4297 Email: info@ladyveteransconnect.org

To our Honored Lady Veteran:

Thank you for your interest in Lady Veterans Connect's transitional housing program. We look forward to learning more about you and your goals while participating in our programs. This information will be valuable to Lady Veterans Connect (LVC) in ensuring that your needs are met.

Enclosed, you will find additional information regarding our program and expectations.

After reviewing the information, please do not hesitate to ask any questions you may have.

Now, let us get you settled into your room and take a tour of Anna's House.

With gratitude for your service to our country.

Phyllis Abbott

Executive Director

11400 Irvine Road, Winchester, Kentucky 40391

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Date: _____

Contact and General Information:

First Name: _____ MI: _____ Last Name: _____

Have you ever been known by another name? Yes: ____ No: ____, if so, what? _____

Age: ____ DOB: _____ SSN: _____ Phone: _____

Race: Asian African-American Caucasian Hispanic Native-American Other _____

*Circle all that apply

Most Current Address: Street: _____ City: _____ State: ___ Zip Code: ____

Marital Status: Single __ Never Married __ Divorced: __ Widowed: __ Significant Other: _____

Emergency Contacts:

Name: _____ Relationship: _____ Phone: _____ Email: _____

Address: Street: _____ City: _____ State: _____ Zip Code: _____

Name: _____ Relationship: _____ Phone: _____ Email: _____

Address: Street: _____ City: _____ State: _____ Zip Code: _____

Military History:

Branch of Service: _____ Dates: From: _____ To: _____ DD-214: _____

Additional Information:

Do you smoke? _____ Use any drugs? _____

Have you had the COVID vaccine? ____, if so, provide a copy of your card. Had COVID? _____

Have you tested positive for any form of Hepatitis or HIV: _____

If so, are you currently being tested? _____

Have you been treated, or are you in need of treatment for the following? (Circle all that apply)

- Alcohol abuse
- Development Disability
- Domestic Violence
- Drug Abuse
- HIV-AIDS
- Mental illness
- Physical Disability
- Other (please specify) _____
- Are you presently using alcohol? _____
- Any drugs? _____ If using any drugs, please list: _____

_____

Mental Health Counseling/Treatment Diagnosis: Yes: ____ No: ____

- When were you last treated?: _____
- Where were you last treated?: _____
- Prescribed Medications: _____

_____

- Have you ever attempted suicide?: _____
- Have you experienced PTSD: If so, describe:

_____

_____

_____

_____

_____

- Have you experienced Military Sexual Trauma (MST): _____ If so, describe:

_____

_____

_____

_____

_____

- Are you presently being treated by the VA or a private provider for any medical issues?:

_____

_____

_____

_____

_____

- Disclose the following health/personal information:
  - All health/personal information:

_____

- ❖ All health/personal information relating to the following treatment or condition:

  _____

  _____

- ❖ My health/personal information covering the period from _____ (date) to _____ (date)
- ❖ If you do not have VA healthcare benefits, explain?:

  _____

  _____

Miscellaneous:

Have you been homeless for at least one year? Yes: ____ No: ____

If not, how many times have you been homeless in the past (3) years?: _____

Where did you sleep last night?: _____

How long have you been sleeping in last night's residence?: _____

In the past thirty (30) days what has been your must current living situation (circle one)?

- Domestic Violence Situation
- Emergency Shelter
- Hospital
- Jail/Prison
- Living with relatives or friends
- None-housing (bus station, car, park, street, etc.)
- Psychiatric Facility
- Rental Housing
- Substance Abuse Treatment Facility
- Transitional Housing for homeless persons
- Other (specify): _____

Describe the Circumstances that led to homelessness:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Children:

- Do you have minor children? Yes: ___ No: ___
- Do you have custody or visitation rights? Yes: ___ No: ___
- Children's names, ages, and gender:
  - Name: _____ Age: _____ Gender: _____
  - Name: _____ Age: _____ Gender: _____

Other:

- Do you have a service animal: _____ if so, reason:

  _____

  _____

  _____

- Do you have a living will or healthcare directive? If so, please identify contact person for this information in case of an emergency:

  _____

- Are you currently employed: Yes: ___ No: ___

What do you hope to achieve by participating in this program?:_____

_____

_____

_____

_____

_____

_____

How did you hear about Lady Veterans Connect?: _____

Understanding:

To the best of my knowledge, I believe that all the information contained in this application is true and complete. I understand that if I knowingly made any false statement this may disqualify me from being eligible for the program. I agree the staff of LVC can check the accuracy of the information in this application by doing a background check or check public records if they choose. I understand that this application is not a guarantee that I will be accepted in the program provided by LVC.

I further understand that the first thirty (30) days will be a trial period, and that if I fail to follow the house rules and participate in designated programs and counseling, I will no longer be eligible to participate in the program and will vacate the premises.

If accepted, I agree to fully participate in the programs and counseling offered by Lady Veterans Connect.

Financial Disclaimer:

I understand that the information provided will be used only to determine my responsibility for financial costs of housing at LVC. I understand that any documents I provide as proof of status will be returned. I understand that the information provided is subject to verification. I certify that all information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Approved by: _____ Date: _____

Lady Veterans Connect

Attach the following:

- A copy of your DD-214
- A copy of your driver's license or other identification

BACKGROUND VERIFICATION RELEASE FORM

I, hereby authorize Lady Veterans Connect to request and receive any and all background information about or concerning me, including but not limited to my Criminal History, Social Security Number Trace, including a consumer report under the Fair Credit Reporting Act, 15 U.S.C. 1681, Driving Record, Employment History from any individual, corporation, partnership, and Law Enforcement Agency.

Signature: _____

Date: _____

Witness: _____

Date: _____

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 24VA10P2 "Patient Medical Record - VA" and in accordance with the 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)	PATIENT NAME (Last, First, Middle Initial)
VA Medical Center Lexington	SOCIAL SECURITY NUMBER

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

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)

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

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):

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 (mm/dd/yyyy)	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

VA FORM JUL 2013 **10-5345**

USE EXISTING STOCK OF VA FORM 10-5345, DATED MAY 2005.