



# warrior salute veteran services

Dear Applicant:

Thank you for your service to our country and for your interest in the Warrior Salute Veteran Services Nucor Transitional Housing Program. We serve and support Veterans with a primary diagnosis of PTSD, TBI, Anxiety, Depression and Military and Sexual trauma. The Nucor Transitional Housing Program is a drug and alcohol- free environment. Enclosed is a packet of information needed for our program and an application for services. ***Please complete the enclosed application. In addition to the completed application, the following information is needed in order for consideration of approval into Warrior Salute Veteran Services Nucor Transitional Housing Program:***

**REQUIRED DOCUMENTS:**

- Enclosed Application (attached)
- Current Medications/Allergies
- Physical (1 year)
- PPD/TB test (1 year)
- DD-214 (Member-4)
- Documentation of 30 days sobriety
- Documentation of continued participating in treatment (i.e. individual and or group therapy, case management services, or community groups)

**REQUESTED IF AVAILABLE:**

- PTSD Screening
- TBI Screening
- Psychological Evaluation (most recent)
- Work Restrictions/Profile

**The program will accept the most recent assessments available for the purposes of intake.**

After you have gathered this information, please fax, email, or mail to:

Jim Stampfer  
Nucor House Manager  
Warrior Salute Veteran Services  
265 Embury Road  
Rochester, NY 14625  
Phone: 585-474-9001  
Fax: 585-347-4326  
[intake@warriorsalute.com](mailto:intake@warriorsalute.com)

Once the application is received, it will be reviewed and you will be contacted. If you have any questions, please contact Jim Stampfer. Again, thank you for your service and for your interest in our agency.

Sincerely,  
Jim Stampfer  
Nucor House Manager

**Mission:** *Warrior Salute Veteran Services provides case management and transitional housing to veterans diagnosed with post-traumatic stress disorder, traumatic brain injury, and military sexual trauma, so they may transition back as vital members of their communities*



## Application

### REFERRAL INFORMATION

Referred by: \_\_\_\_\_ Contact # \_\_\_\_\_  
Organization: \_\_\_\_\_ Fax # \_\_\_\_\_  
Email: \_\_\_\_\_

### VETERAN INFORMATION

Veteran's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Sex:  Male  Female Social Security # \_\_\_\_\_ DOB: \_\_\_\_\_  
Email: \_\_\_\_\_  
Current Residence: \_\_\_\_\_  
Permanent Residence: \_\_\_\_\_  
Have you previously received services through Warrior Salute: out-patient \_\_\_\_\_ residential \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
  
Alternative Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Domestic Partner

### ARMED SERVICES HISTORY

Branch: \_\_\_\_\_ Service Dates: \_\_\_\_\_ D/C Status: \_\_\_\_\_  
Deployment History: \_\_\_\_\_  
Narrative Reason for Separation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MEDICAL INFORMATION

Traumatic Brain Injury  Neurological Impairment  Epilepsy (type): \_\_\_\_\_  
 Mental Health Diagnoses: \_\_\_\_\_  
 Medical Diagnoses: \_\_\_\_\_  
 Physical needs (specify): \_\_\_\_\_  
 Drug Allergies: \_\_\_\_\_  
 Food Allergies: \_\_\_\_\_  
 Environmental: \_\_\_\_\_  
 OTHER: \_\_\_\_\_

History of alcohol or illegal drugs, if yes please list below:

Drug(s) of Choice: \_\_\_\_\_ Last Used: \_\_\_\_\_



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**SI/HI:**

Suicidal Ideation: \_\_\_\_\_

Suicide Attempt: \_\_\_\_\_

Homicidal Ideation: \_\_\_\_\_

Homicidal Acts: \_\_\_\_\_

**Current Medications:** *(please list all medications)*

_____	_____
_____	_____
_____	_____

**Legal Involvement:** \_\_\_\_\_

**Vocational Goals:** \_\_\_\_\_

**What are your personal goals while in the Warrior Salute Veteran Services Nucor Transitional Housing Program?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**BENEFITS** *(list amounts if applicable)*

- SSI       SSD       Public Assistance       Other Wages       VA Pension  
 VA Service Connection/Disability Rating Percentage:

Other: \_\_\_\_\_

**MOBILITY STATUS:** (Check all that apply)

- Ambulatory       Manual Wheelchair       Able to Negotiate Stairs       Power Wheelchair  
 Other: \_\_\_\_\_

**ADAPTIVE EQUIPMENT:** (Check all that apply)

- Communication Device       Wheelchair       Computer       Mobility Device  
 Hearing Aid       Eye Glasses       Other: \_\_\_\_\_

**TRANSPORTATION:**

- Valid Driver's License       Suspended License       Has own vehicle       No Vehicle

Insurance Information: \_\_\_\_\_

**COMMUNICATION:**

Primary Language: \_\_\_\_\_

Requires an Interpreter:  Yes       No

Verbal:  Yes       No

Uses Sign Language:  Yes       No

**SERVICES CURRENTLY RECEIVING:**

- Case Management       Psychiatry/Psychology       Counseling       Social Work  
 OT       PT       Speech       Nursing       Other: \_\_\_\_\_



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## **CURRENT SERVICE PROVIDERS**

Primary Care Physician: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email: \_\_\_\_\_ Fax #: \_\_\_\_\_

Mental Health Professional: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email: \_\_\_\_\_ Fax #: \_\_\_\_\_

Specialist (Specify): \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email: \_\_\_\_\_ Fax #: \_\_\_\_\_

Specialist (Specify): \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email: \_\_\_\_\_ Fax #: \_\_\_\_\_

Specialist (Specify): \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email: \_\_\_\_\_ Fax #: \_\_\_\_\_

## **Consent to Receive Services/Assessment**

I, \_\_\_\_\_ understand that this application will be reviewed by the Warrior Salute Veteran Services Nucor Team and Medical Director.

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## Consent for Release of Information

Name: \_\_\_\_\_ Last four of SS#: \_\_\_\_\_

\_\_\_\_\_ I hereby give permission to the Warrior Salute Veteran Services to receive information from:

Person (s): \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

\_\_\_\_\_ I hereby give permission to the Warrior Salute Veteran Services to release information to:

Person (s): \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

I hereby give permission for information to be shared in the following format:

- Phone       Fax       Writing       e-mail       In person

I hereby give permission for the following information to be shared:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Intake Assessment  | <input type="checkbox"/> PRI Screening  | <input type="checkbox"/> Orthopedic Evaluation          |
| <input type="checkbox"/> Treatment Plan   | <input type="checkbox"/> PTSD Screening   | <input type="checkbox"/> Social Work Evaluation         |
| <input type="checkbox"/> Psych/Neuropsych. Evaluation                               | <input type="checkbox"/> Medical History (including physicals, lab results and medications/allergies) | <input type="checkbox"/> Employment History/Evaluations |
| <input type="checkbox"/> Mental Health History                                      | <input type="checkbox"/> PPD/TB test (1 year)   | <input type="checkbox"/> Academic Performance           |
| <input type="checkbox"/> Drug & Alcohol Evaluation                                  | <input type="checkbox"/> OT/PT/Speech Reports   |   |
| <input type="checkbox"/> Other (Please specify, i.e. Military/Sexual trauma): _____ |   |   |

Information will be shared for the following purpose: \_\_\_\_\_

I understand that this authorization covers only the information indicated and that Warrior Salute Veteran Services will maintain the confidentiality of the information. This authorization is valid from one year from the date signed unless I choose in writing to revoke earlier. The information obtained from the use of this release may only be used for the purpose of which it was intended **and authorized**.

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_