OPERATION DIGNITY

Veteran Application for GPD Transitional Housing

Thank you for applying to Operation Dignity's Grant and Per Diem (GPD) program. This program provides transitional housing and services to veterans experiencing homelessness. We are able to serve single men, single women, and a small number of families with children, though availability of beds varies.

Please answer the questions in this form to help us determine whether you are eligible for GPD and how our program can best serve you. Please note that we must verify your eligibility with the VA before enrolling you into our program.

You can deliver this application in the following ways:

1. Fax it to **510-287-8469**, OR

2. Drop it off at our main office at **3850 San Pablo Ave., Ste. 102 in Emeryville**. We are open Monday through Friday, 8:30 a.m. to noon and 1 p.m. to 4:30 p.m.

If you have any questions, please call us at **(510) 287-8465**.

By signing below, you confirm that all information in this application is true and correct to the best of your knowledge. You also authorize Operation Dignity to contact any other service providers named below for information that will help in providing you with services.

Signature: _____ Date:_____

FOR REFERRING AGENCY (if applicable – leave blank if you are the veteran filling this application out for yourself):

1. Name of the person referring veteran:_____
2. Agency name: _____
3. Agency telephone: _____

Please also fill out the "Authorization to Release Referral Information" in this packet.

OPERATION DIGNITY
APPLICATION FOR TRANSITIONAL HOUSING

Date: ____/____/_____

Full name (including middle name): _____

Social Security Number: _____ Date of Birth: ____/____/_____

Current/ Last Address:

_____

Best phone number to reach you: _____

Have you ever stayed at one of Operation Dignity's programs before?

□ Yes □ No

Do you have a current or pending housing subsidy or voucher (e.g. SSVF, VASH, or Section 8)? □ Yes □ No

If yes, which agency are you working with (e.g., VASH, Swords to Plowshares, EOCP)? _____

Do you have any history of substance/alcohol use? □ Yes □ No

If yes, please list substance(s) and date last used _____

Do you have any history of mental health conditions? □ Yes □ No

If yes, are you under the care of a psychiatrist? □ Yes □ No

Have you ever been hospitalized for your condition? □ Yes □ No

Do you or a does member of your household need reasonable accommodation due to a disability (such as a first floor room or service animal)? □ Yes □ No

Do you have any medications that need to be refrigerated? □ Yes □ No

Have you or a household member ever been subject to any sex offender registration program in any state? □ Yes □ No

Have you ever been convicted of arson? □ Yes □ No

Are you currently on probation or parole? □ Yes □ No

If yes, what are the conditions of your probation or parole? (e.g., limitations on where you can live): _____

ADDITIONAL DOCUMENTS:

If you have the following documents available, please submit them with this form and check them off under **"Included with my application."**

If you are missing any documents, please check the box labeled "**I do not have this document."** If you are enrolled, your case manager will help you obtain them.

	PLEASE CHECK ONE:	
Document	**Included with my application.**	**I do not have this document.**
Proof of Military Service (DD 214 or equivalent)		
Government-Issued Photo ID		
Social Security Card		
Verifiable Proof of Income (if any)		

ADDITIONAL INFORMATION:

If there is any other information you would like to add to your application, please use the space below:

_____

_____

_____

_____

_____

VETERANS WITH FAMILIES:

Please ONLY fill out this page if you are seeking transitional housing for yourself and your household (including minor children). If you are a single adult, you do not need to fill out this page.

How many adults (age 18 or over) are in your household? _____

Additional Adult Family Member(s):

Full name	**Gender (M/F)**	**DOB**	**Social Security #**	**Relationship**
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

How many children (under 18) are in your household? _____

Full name	**Gender (M/F)**	**DOB**	**Social Security #**	**Relationship***
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

*Child, Step Child or Other

Do you expect any additions to your household in the next year? □ Yes □ No

Do you or any member of your household share custody of any child(ren) listed above with someone not in your household? □ Yes □ No

If yes, please explain custody arrangements _____

_____

AUTHORIZATION TO RELEASE REFERRAL INFORMATION

I, (applicant) _____ authorize (referring agency) _____ to release the information contained in the referral application to Operation Dignity. I authorize the exchange of information between the above named Agency and Operation Dignity in order to complete the referral process and verify my eligibility for services and housing.

I understand that such information will only be used for program purposes related confirming service eligibility and assessing how to best assist me in receiving services. This information is confidential and will not be released by the above stated agencies without written permission by me. This authorization is valid for a period not to exceed one year from the date of this signed release.

I understand that I have the right to revoke this authorization at any time by submitting a written request to the agency releasing the information requested above. I understand that revocation will not apply to information that has already been released.

I understand the recipient of this information will not further use, transfer, nor re-disclose this information to any person or entity unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Applicant's Signature: _____ Date: _____

Interviewer's Signature: _____ Date: _____

I have received a copy of this authorization.
Applicant's Initials: _____

A photocopy of this authorization is as valid as the original.
Applicant's Initials: _____

Notification of CA/National Sex Offender Registry Search

Operation Dignity conducts a search of California and national sex offender public registry databases on every person referred to or receiving services.

If you are found to have any history of sexual offence that requires you to register as such under California and/or U.S. Law, you may be denied/terminated from the program. This only applies to sex offenders who are required by law to register.

In addition, Operation Dignity will search the registries every December. If a current participant appears in a database, their services may be terminated.

If a collaborative partner discloses to staff that an Operation Dignity participant is registered as a sex offender, Operation Dignity will check the databases to verify this information. If the participant appears in a database, their services may be terminated.

If an Operation Dignity staff member identifies a person registered with a sex offender database, the staff member will make every reasonable effort to maintain the registrant's privacy while enforcing any denial or termination of services.

If your name is listed and you believe that the registry is not correct, you may choose to appeal any decision for denial/termination of services.

You hereby acknowledge that you have been informed that Operation Dignity will conduct a search of your name in the national and California sex offender registries at www.nsopw.gov and www.meganslaw.ca.gov. You understand that such information will only be used to inform service eligibility and any placement.

You understand that you have the right to receive a copy of this notification:
A copy was issued: _____ declined:_____

Applicant's signature: _____ Date: _____

A photocopy of this authorization is as valid as the original.

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)*
Northern California Health Care System
150 Muir Road, Martinez, CA 94553

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
Operation Dignity (OD) 3850 San Pablo Ave Suite #102 Emeryville,CA 94608.(Includes intake staff & case managers located at OD's main office; House of Dignity (HOD); Dignity Commons(DC); Ashby House (AH) and Operation Dignity Emergency Shelter (ODES) sites.

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

☒ TREATMENT ☒ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☒ OTHER *(Please specify)* Coordination of care

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: ppd or chest x-ray for program clearance purposes

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☒ LIST OF ACTIVE MEDICATIONS: _____

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☒ OTHER *(Describe)*: Verbal/written exchange of medical information related to ongoing care

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 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 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.

☐ 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): For the duration of my participation in OD's Grant & Per Diem (GPD) program/s &/or Contracted Emergency Shelter (CERS)-ODES

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	RELEASED BY: