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:

____

____

____

____

____

<u>VETERANS WITH FAMILIES:</u>

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: _______

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)

VA Northern CA Healthcare System
150 Muir Road,Martinez, CA 94533

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

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; HOD/ODES, DC & AH property sites).

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)

Verbal and written exchange of medical information (ie-ppd results; chest X-ray results; upcoming appointments; attendance at appointments; diagnoses and urinalysis results)

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

Coordination of admission, on-going care, services and healthcare operations.

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):

For the duration of my participation in the Grant & Per Diem (GPD) Programs Low Demand (LD); Bridge & Service Intensive Transitional Housing (SITH)and/or in the Operation Dignity Emergency Shelter (ODES) Program

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

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.