

Veteran's Name: (Last, First, MI) _____ SSN: _____ DOB _____

Fax completed application to Application Review Committee: (352) 548-1850

The Residence at the HONOR Center Domiciliary (Agency Referral) Application

Providing Hope, Opportunities, Networking, Outreach, and Recovery to Homeless Veterans

The Residence at the HONOR Center is a transitional residence for Veterans who are homeless or at risk of homelessness and could benefit from residential rehabilitation level of care due to medical needs.

Yes	No	Is eligible to receive VA health benefits
Yes	No	Assessed as not meeting criteria for acute psychiatric or medical admission
Yes	No	Assessed as not a significant harm to self
Yes	No	Assessed as not a significant risk of harm to others
Yes	No	Lacks a stable lifestyle or living arrangement that is conducive to recovery
Yes	No	Capable of basic self care/able to meet activities of daily living (ADLs)

Our building and grounds are smoke-free and tobacco-free environments.

Veterans are required to comply with program rules and meet with an interdisciplinary team to compose a treatment plan which will focus on stabilization of medical and housing needs.

Name Veteran prefers to be called: _____

Reason for Domiciliary referral: Veteran's current living situation, the need for residential medical care and how long veteran expects to stay:

Does the Veteran have any of the following? If yes, please give contact information:

Durable Power of Attorney? Yes No _____

Health Care Surrogate? Yes No _____

Do Not Resuscitate? Yes No _____

Living Will? Yes No _____

Appointed Legal Guardian/Fiduciary? Yes No _____

HEALTH: Attach additional information as needed

PHYSICAL HEALTH

Current diagnoses/conditions: _____

Veteran's Name: (*Last, First, MI*) _____ **SSN:** _____ **DOB** _____

When/where Veteran was last seen for medical care: _____

Current Medications (attach list if lengthy): _____

History of falls? Yes No If so, date of last fall? _____

Please list any special needs: _____

MENTAL HEALTH (Including substance abuse)

Current diagnosis/conditions: _____

When/where Veteran last seen for mental health care: _____

Current Medications (attach list if lengthy): _____

Suicide Risk Screen:

- | | | |
|---|-----|----|
| 1) Has the Veteran had thoughts of killing self in the past three months? | Yes | No |
| 2) Does the Veteran have a plan for self harm or suicide? | Yes | No |
| 3) Does the Veteran have the means to carry out a plan? | Yes | No |
| 4) Does the Veteran intend to carry out this plan? | Yes | No |
| 5) Does the Veteran have a history of prior suicide attempts? | Yes | No |
| 6) Has the Veteran heard voices instructing to harm or kill self? | Yes | No |
| 7) Has anyone in the Veteran's family ever attempted suicide? | Yes | No |

Income:

Employed? Yes No Employment a goal? Yes No

Compensation and Pension or Disability Application? Started Needed

Income:

Is Veteran currently involved in a case management program? Yes No If so, what is the case manager's name and contact information: _____

Family and Friends:

Contact information for family/friends: _____

What are the Veteran's short and long term housing goals? _____

Veteran's Name: (Last, First, MI) _____ SSN: _____ DOB _____

Referring source:

Provider: _____ Program: _____

Address: _____

Phone: _____ Cell: _____ Fax: _____

Veteran understands and accepts that The Residence at the HONOR Center is a smoke-free and tobacco-free environment.

Veteran needs assistance to participate in an admissions screening: Yes No

Veteran's Signature: _____ **Date:** _____

Contact Address: _____

Contact Phone Number(s): _____ Fax: _____

Fax completed application to:
The Residence at the HONOR Center
Attn: Application Review Committee
Fax: (352) 548-1850
Phone inquiries: (352) 548-1800