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

Please fill out the application to the best of your ability. Leaving blanks is OK.

The Residence at the HONOR Center Domiciliary Application
providing
Hope, Opportunities, Networking, Outreach, and Recovery to homeless Veterans

VETERAN INFORMATION

Name (Veteran):_____Referred By:_____

Address: _____

BEST WAY TO CONTACT VETERAN:_____

The Residence at the HONOR Center is a transitional residence for Veterans who are homeless or at risk of homelessness and could benefit from a residential rehabilitation level of care due to medical need or disability. Veteran meets following criteria. (circle yes or no)

Yes *No* Eligible to receive VA health benefits
Yes *No* Does not need acute psychiatric or medical admission
Yes *No* No risk of significant harm to self
Yes *No* No risk of significant risk of harm to others
Yes *No* Lack of 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)

Does veteran have any of the following? (Circle Yes or No)(If Yes, Provide contact information)

Yes *No* Durable Power of Attorney?
Yes *No* Health Care Surrogate?
Yes *No* Do Not Resuscitate?
Yes *No* Living Will?
Yes *No* Appointed Legal Guardian/Fiduciary?

Our building and grounds are a smoke-free and tobacco-free environment.

The Veteran is required to comply with program rules and meet with an interdisciplinary team to compose a treatment plan focused on medical and housing needs.

WHY DOES VETERAN NEED A DOMICILIARY?

Veteran's current living situation:_____

_____

The need for residential medical and/or mental health care: _____

_____

How long Veteran expects to stay:_____

Providers Only

Provider:_____ Date Referred _____ Phone:_____

Office use only

Date Received _____ Appointment Date_____ Date screened: _____

Date of Admission Decision_____ Why?_____

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

HEALTH: Attach additional information as needed

PHYSICAL HEALTH

Current diagnoses/conditions:

When/where Veteran was last seen for medical care:

Current Medications (attach list if lengthy):

History of falls(circle one)? *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 (Circle Yes or No):

Yes No 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?

ENVIRONMENTAL FACTORS

INCOME: $_____/month Source : _____

Employed(circle one)? *Yes No* Employment a goal(circle one)? *Yes No Disabled Retired*

Compensation and Pension or Disability Application(circle one)? *Started Needed*

Is Veteran currently involved in a case management program(circle one)? *Yes No*

Case manager's name: _____ phone #:_____

FAMILY and FRIENDS:

Name/Relation _____ Phone/Contact_____

Name/Relation _____ Phone/Contact_____

HOUSING GOALS

Short Term(circle one): *Stay w/Family or Friend VOA Grant and per diem HUD-VASH Other*_____
Long Term(circle one): *Stay w/Family or Friend VOA Grant and per diem HUD-VASH Other*_____

CURRENT LEGAL ISSUES(Circle) Yes No_____

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

Application was filled out by(circle one): ***Self*** ***Friend/Family*** ***Social Worker/provider***

Veteran will need assistance with the admission screening process(circle one): Yes No

Veteran understands and accepts that

The Residence at the HONOR Center is a smoke-free and tobacco-free environment.

Signature of Veteran_____**Date**_____

Fax completed application to:

The Residence at the HONOR Center

Attn: Application Review Committee

Fax: (352) 548-1850

Phone inquiries: (352) 548-1800 or 1-877-730-8387

Location: 1604 SE 3rd Ave.

Gainesville, FL 32641

Only fill out this box if you are a provider

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.

Signature Referring Agent_____ **Date**_____