Veterans Northeast Outreach Center

Transition in Place

10 Reed Street, Haverhill, MA 01832
Phone: (978) 907-8507 Fax: (978) 891-8319
gpdtip@vneoc.org

Date & Time Application was received:
_____
MM/DD/YYYY AM PM
(for office use only)

Referring Agency/ Person: _____ Phone #: _____
Fax #: _____ Date: _____
Veteran's Name: _____ Phone #: _____
SSN: _____ DOB: _____ Age: _____
Gender: ☐Male ☐Female ☐Other ☐Refuse Ethnicity: ☐HIS or ☐NON-HIS Race: _____
Disabled: ☐Yes ☐No *If Yes,* ☐Physical ☐Mental ☐Cognitive – Able to live independently? ☐Yes ☐No
Previous Admission to VNOC? ☐Yes ☐No / If yes, please list programs? _____
_____
Eligible for VA Medical ☐Yes ☐No Service Connected: ☐Yes ☐No If YES, Percent: _____%
DD214 ☐Yes ☐No Branch of Service: _____ Discharge Status: _____
Active Duty – time other than training? ☐Yes ☐No Total # of active duty days other than training? _____

Program/Service(s) Requested----------

- ☐ Grant per Diem Bridge
- ☐ Grant per Diem TIP
- ☐ SSVF
- ☐ Housing / HUD
- ☐ Immediate Shelter
- ☐ Job Assistance
- ☐ Education
- ☐ Training
- ☐ Benefits Assistance
- ☐ Transportation
- ☐ Emergency Assistance
- ☐ Child Support
- ☐ Other: _____

Employment & Income History----------

Total Income: _____ / _____ Is Veteran Working: ☐Yes ☐No
Current/ Previous Employer Name: _____
Job Title: _____ Start/End Date_____ Hourly Wage $ _____ Weekly Hours: _____

Unemployment Comp	Amount:$_____/_____	SSI	Amount:$_____/_____
Child Support	Amount:$_____/_____	SSDI	Amount:$_____/_____
Social Security Ret	Amount:$_____/_____	Pension	Amount:$_____/_____
Workers' Comp	Amount:$_____/_____	SVC CON Disability	Amount:$_____/_____
Chapter 115/NON-SVC	Amount:$_____/_____	Other Source of Income	Amount:$_____/_____

Highest LVL of education: _____ Are you currently enrolled in school: ☐Yes ☐No
Do you wish to participate in our DOL – funded workforce reintegration program..... ☐Yes ☐No
Do you have a valid driver's license? ☐Yes ☐No Do you have your own private transportation? ☐Yes ☐No

Housing needs----------

Current Housing Status: ☐ Homeless ☐ Imminent risk of homelessness (with-in 14 Days) ☐ Housed / but at Risk (with-in 30 days)
☐ Inmate/Jail diversion ☐ Family/ Friends (couch surfing) ☐ Subsidized Housing (VASH/ Voucher)

☐ VA in-patient program ☐ Other: _____

Current or last address that you lived at and 2 prior addresses:

Dates of tenancy: _____ to _____ Reason for Leaving _____

Previous address: _____

City: _____State: _____Zip Code _____

Dates of tenancy: _____ to _____ Reason for Leaving _____

Previous address: _____

City: _____State: _____Zip Code _____

Dates of tenancy: _____ to _____ Reason for Leaving _____

Previous address: _____

City: _____State: _____Zip Code _____

Have you ever had a VASH voucher? ☐ Yes ☐ No Have you ever lived in subsidized housing? ☐ Yes ☐ No

Have you ever been evicted? ☐ Yes ☐ No If yes, how many times? _____

Do you have any rental or utility arrears that were not paid? ☐ Yes ☐ No If yes, total amount? _____

What Unit Size is needed: ☐ SRO ☐ 1BRM ☐ 2 BRM ☐ Other _____

Other Household Members:

Name: _____ Relationship:_____ DOB: _____ Income/Source:_____

Name: _____ Relationship:_____ DOB: _____ Income/Source:_____

Name: _____ Relationship:_____ DOB: _____ Income/Source:_____

Does Veteran require a handicap accessible unit? ☐ Yes ☐ No List any modifications or special accommodations needed: _____

Does Veteran or household member require the use of an emotional support/service animal? ☐ Yes ☐ No

Substance Misuse History----------

Is Veteran currently engaged in Treatment: ☐ Yes or ☐ No

If Yes, when did you start? _____Where: _____

Drug most recently abused: _____ Date of Sobriety: _____

Is Veteran involved in a methadone maintenance program? ☐Yes ☐No Where: _____

Mental Health Diagnosis: ☐Yes ☐No ☐N/A Does Veteran have a history of suicide attempts? ☐Yes ☐No

Therapist Name and Phone: _____

Diagnosis: _____

Medications for Mental Health: _____

Psychiatric Hospitalization(s): _____

Cognitive Issues: *(i.e. Traumatic Brain Injury, TBI):* ☐Yes ☐No ☐Unknown ☐N/A

Specialist Name and Phone: _____

Diagnosis: _____

Medications for Cognitive Health: _____

Major Medical Issues: *(i.e. diabetes, heart disease, contagious infections)* ☐Yes ☐No ☐N/A

Diagnosis: _____

Medications for Medical Issues: _____

Legal History---------- Does the Veteran any current or pending charges? ☐ Yes or ☐ No

Has Veteran ever been Arrested and/or Convicted: ☐ Yes or ☐ No Current Court Involvement ☐ Yes or ☐ No

☐ Open Charges ☐ Open Warrants ☐ Active Probation ☐ Restraining Orders

If yes what are the charges/dates: _____

Has Veteran ever been charged or convicted of a Sexual Offense? ☐ Yes or ☐ No

(If yes, explain): _____

_____

Has Veteran ever been charged or convicted of a Domestic Violence Offense? ☐ Yes or ☐ No

(If yes, explain): _____

_____

Probation/Parole Officer Name: _____ Phone#: _____

Name of Court: _____ Date of Next Appearance: _____

Does the Veteran have a history of Violence? ☐Yes ☐No If yes, explain: _____

_____

Does the Veteran have a history of Arson? ☐Yes ☐No If yes, explain: _____

_____

Any other significant barriers in the veteran's life: _____

_____

_____

_____

Why do you feel that GPD TIP Housing is a good fit for you? _____

_____

_____

Anything else that you feel that the GPD staff should know when considering you for GPD admission?

_____

Level of Care Assessment, Activities of Daily Living, ADL:

ADL General	No Help Needed (Independent)	Some Help Needed	Extensive Total Help
Dressing: Upper Body	☐	☐	☐
Dressing: Lower Body	☐	☐	☐
Hygiene: Hands, Face	☐	☐	☐
Hygiene: Hair,Teeth,Shaving	☐	☐	☐
Hygiene: Showering	☐	☐	☐

Locomotion: Walking, Wheelchair	☐	☐	☐
Dining: Set Up, Self-Feeding	☐	☐	☐
Mobility: In/Out Bed, Chair	☐	☐	☐
Mobility	☐walker	☐wheelchair	☐both

Bowel/Bladder	No Help Needed (Independent)	Some Help Needed	Extensive Total Help
Bowel: Continence needs	☐	☐	☐
Bladder: Incontinence needs	☐	☐	☐

Mental/Cognitive Status

Alert/Orientated (time, place person)	☐Yes	☐No
Memory Loss (short term)	☐Yes	☐No
Memory Loss (long term)	☐Yes	☐No
Wanders	☐Yes	☐No
Any challenging behaviors?	☐Yes	☐No

*This includes things like being disruptive, agitated, or aggressive, abusive, demanding, and/or requiring frequent staff interventions. Is this prospective resident delusional or has hallucinations? Please describe prospective resident's emotional status, personality, and demeanor; _____

_____

_____

_____

_____

_____

Supporting Documents: *(Please attach as many of the following as possible)*

State ID: ☐Yes ☐No DD-214 (*Member-4) (most recent)*: ☐Yes ☐No Recent proof of income: ☐Yes ☐No

Social Security Card: ☐Yes ☐No US Birth Certificate: ☐Yes ☐No Problem List: ☐Yes ☐No ☐N/A

Psychosocial: ☐Yes ☐No Current Medication List: ☐Yes ☐No US Passport: ☐Yes ☐No ☐N/A

_____ _____

Signature and Title of Person Completing this form Date: MM/DD/YYYY

Please return the completed application and support documentation to:

Rachel Hagen

TIP Program Manager
(978) 891-8304