BREAKING GROUND
BUILDING AND RESTORING LIVES

VETERANS TRANSITIONAL RESIDENCE
HOUSING APPLICATION

Thank you for your interest in applying for housing at the Breaking Ground Veterans Transitional Residence Community (TRC), located on the VA Hudson Valley Campus in Montrose, NY.

In order to be eligible for this housing, all applicants must meet the following requirements:

- Must be a homeless veteran eligible to receive VA services
- Must be in need of supervised living arrangement and case management services
- Must not be in need of acute psychiatric or medical care
- Must demonstrate 30 days of sobriety
- Must have a source of income
- Cannot have a sexual offense conviction(s)

All applications must include the following documents (<u>please</u> include this completed checklist when submitting your application):

- ☐ Breaking Ground Veterans Transitional Residence Application (attached)
- ☐ Prospective Resident Agreement (attached)
- ☐ Signed release of information consent forms (attached)
- ☐ Proof of homelessness – letter from outreach team or shelter provider
- ☐ Psychosocial – must be 90 days current (Note psychosocial must include proof of demonstrated length of sobriety)
- ☐ Psychiatric evaluation – must be 90 days current
- ☐ Medical evaluation, including PPD results – must be 90 days current
- ☐ Proof of income – must be 90 days current
- ☐ Copy of valid photo ID
- ☐ Proof of military service & nature of discharge (Form DD-214)

Completed applications should be mailed or faxed to:

Breaking Ground
Veterans Transitional Housing
PO Box 487
Montrose, NY 10548

Fax #: 914-788-1368

For more information, questions about this program or your eligibility, please call 914-606-3480.

All information obtained is confidential and will be used for application review purposes only. Breaking Ground maintains a firm commitment to equal opportunity for all applicants. Breaking Ground y does not discriminate based on race, sex, age, color, national origin, religion, sexual orientation, HIV status, or disability.

TRANSITIONAL RESIDENCE COMMUNITY INTAKE FORM

Please complete **all** sections and sign the last page. **PLEASE PRINT LEGIBLY.**

Contact Information

Name: _____ **Alias**: _____

Date of Birth (mm/dd/yy): _____ **Gender**: ☐ Male ☐ Female

SSN: _____ **Contact Number**: _____

Housing Status

Current Address: _____
_____

Type of Housing: (please check all that apply):
☐ Shelter ☐ Rental Housing ☐ Living w/ Friend/Relative ☐ Streets
☐ Jail/Prison ☐ Hospital ☐ Substance Abuse Treatment Program
☐ Psychiatric Facility ☐ Transitional Housing ☐ Other

How long have you been living at this address? _____ years/months

Do you currently pay any rent/utility bills? ☐ **Y** or ☐ **N** If yes, how much? _____ month

Where were you living before your current address? _____
_____
_____

Employment History
Current employment status: ☐ Employed ☐ Unemployed ☐ Retired

If employed, occupation? _____

Employer's name: _____
Address: _____
_____
Phone #: _____

How long have you worked in this position? _____ years/months

Average gross pay? _____
(*circle one*): weekly/bi-weekly/monthly/annually

Other Sources of Income
Please list all other sources of income that you receive, such as public assistance, veteran's health benefits, social security income and/or disability, pension, unemployment compensation, alimony, etc.

Source of Income	Amount $	Length of Time Receiving
	$ per	
	$ per	
	$ per	
	$ per	

Assets
Do you have any type of savings? ☐ **Y** or ☐ **N**

If yes, please check all that apply and provide amounts:

☐ Checking $ _____ ☐ IRAs/Retirement Accounts $ _____
☐ Money Market $ _____ ☐ Savings $ _____ ☐ CDs $ _____
☐ Stocks/Bonds $ _____ ☐ Other (specify) $ _____

Military History (years of service, branch, discharge information):

Legal History (conviction, dates/years served, parole/probation)

Have you been convicted as a sexual offender? ☐ **Y** or ☐ **N**

Have you been convicted of a sexual offense e.g. assault, abuse, rape, etc? ☐ **Y** or ☐ **N**

Why are you interested in housing at the Breaking Ground Transitional Residence Community?

_____

_____

_____

_____

Thank you for taking the time to complete this application. Please be advised that completing this application does not guarantee admission to Breaking Ground Transitional Housing Program. This application is a pre-requisite to determine if an interview will be granted to further assess admission to the program.

I hereby affirm that, to the best of my knowledge, the foregoing information is true, accurate, and complete. I understand that misleading or false statements, misrepresentations, or incomplete information in this application will be grounds for rejection and not being granted an interview. I further understand that the information contained within this application will be shared with, the VA Grant and Per Diem Liaison or designee at Hudson Valley Health Care System, for the purpose of determining if an interview should be granted.

_____ _____

APPLICANT'S SIGNATURE **DATE**

FOR INTERNAL USE ONLY

Reviewer's Name: _____

Agency: _____

Date (mm/dd/yy): _ _ / _ _ / _ _

Interview Scheduled For (mm/dd/yy): _ _ / _ _ / _ _

Time: _____ AM or PM

Applicant Contacted (mm/dd/yy): _ _ / _ _ / _ _

Transitional Residence Community Prospective Resident Agreement

Prior to acceptance into Breaking Ground's Transitional Residence Community (TRC), I understand that I **must** review and sign this Prospective Resident Agreement. The purpose of this Agreement is to outline participant expectations for this housing program. Signing this Agreement **does not** guarantee admission to the TRC Program.

PROGRAM EXPECTATIONS:

(PLEASE INITIAL NEXT TO EACH ITEM INDICATING UNDERSTANDING & AGREEMENT)

_____ I understand the maximum length of stay is 24 months.

_____ I am responsible for monthly VA Grant and Per Diem (G&PD) program fees (30% of total income) to help subsidize the cost of my care in the TRC Program. CGC and the VA will evaluate the total value of my present income in order to calculate my share of VA G&PD program fees. I further understand that the Veteran's Housing Program can re-evaluate my income during the time that I am receiving housing assistance and can make program fee adjustments as needed. If there is any change in my financial situation during occupancy, I will notify CGC within 10 days of that change. CGC may recalculate my program fees based on changes in my income.

_____ I understand that the intent of the VA Grant and Per Diem program and the TRC Program is to help me continue my recovery efforts and become more independent. Further, I understand that all program participants may be affected by my behavior. Therefore I accept and agree that any use of drugs/alcohol by me is COMPLETELY PROHIBITED in the TRC Program.

_____ I agree to submit to breathalyzer, blood alcohol, and/or urine drug screenings upon request of the VA or CGC staff. Failure to do so may result in my being discharged from the TRC Program.

_____ I understand that any threatening, aggressive, assaultive, dangerous, or illegal conduct will result in IMMEDIATE discharge.

_____ I understand that after 24 hours of an unexcused absence, I may be discharged from the TRC Program.

_____ I understand that authorized absences for personal or medical reasons cannot exceed 7 days. After the 7th day I will be discharged from the TRC Program and will need to locate alternative housing.

_____ I understand that there is weekday curfew of 10 pm Sunday – Thursday and a weekend curfew of 12 am Friday and Saturday.

I HAVE READ, UNDERSTAND, and AGREE TO ADHERE BY THE TERMS OF THIS AGREEMENT IF ADMITTED TO THE TRC PROGRAM. ADDITIONALLY, I UNDERSTAND THAT INFORMATION CONTAINED WITHIN THIS DOCUMENT WILL BE SHARED WITH THE VA. I FURTHER UNDERSTAND THAT THE ABOVE LIST IS NOT ALL-INCLUSIVE and THERE WILL BE ADDITIONAL REQUIREMENTS. I WILL BE GIVEN AN OPPORTUNITY TO READ and UNDERSTAND THESE REQUIREMENTS PRIOR TO MOVING INTO THE TRC.

APPLICANT PRINT NAME: _____

_____ _____

APPLICANT'S SIGNATURE **DATE**

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 Hudson Valley Health Care System
PO Box 100, Montrose, NY 10548

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

Breaking Ground, TRC Program, PO Box 487, Montrose, NY 10548
Ph: 914-606-3480 fax:914-788-1368/914-606-3479

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)

Ongoing Verbal communication re: eligibility & coordination of services & referrals for medical, mental health, substance abuse, family & legal issues and income as needed.

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

For the purpose of providing, screening assessment, treatment planning, and discharge planning services to assist in resolving homelessness, per vet request.

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):

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

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☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

Written information for coordinating/planning. program application. on request appt list, PPD, C- x-ray, h&p, psychosocial mental health evaluation, urine drug screens, DD214.

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

For the purpose of planning and continuation of care as per request.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

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