**Veterans Northeast Outreach Center**

**Transition in Place**

Date & Time Application was received:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM/DD/YYYY AM PM

*(for office use only)*

10 Reed Street, Haverhill, MA 01832

Phone: (978)-891-4944 Fax: (978)-891-8319

gpdtip@veteranbenefits.us

**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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

(If yes, explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 Some Help Extensive

(Independent) Needed 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 Some Help Extensive

(Independent) Needed 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; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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

**Return completed form to:** VNOC Randy Carter. Fax #: 1(978)-891-8304