Veteran's Progress & Recovery Services

Intake Application

Incomplete applications will be rejected!

veteransprogressandrecovery@gmail.com
www.vprservices.com

For assistance, please contact 832-781-3331

Thank you for considering Veteran's Progress & Recovery Services as a choice for your housing needs.

If acting on behalf of the proposed resident, also attach a copy of guardianship documentation or a signed durable medical power of attorney. For your own security, applications are not accepted online due to the personal nature of the information contained in them. You will need to mail or email the application directly to Veteran’s Progress & Recovery Services.

Please answer all of the questions contained in this application. If an item is not applicable, please write "Not Applicable" or "N/A" in the space provided for an answer. If you need more room to answer any of these questions, you may insert a personal note to this form. After you have substantially completed and returned this form to veteransprogressandrecovery@gmail.com

If you have questions as you are completing the application, please contact Veteran's Progress & Recovery Services (VPRS), 832-781-3331.

Intake Application

Today's Date _____

Applicant's Name _____

Category: Veteran ☐ Senior ☐ Disabled ☐ Surviving Spouse ☐

Senior Couple ☐ Veteran Parent ☐ Homeless w/income ☐

PERSONAL INFORMATION:

How did you hear about us? _____

_____

Date of Birth _____ Current Age_____Gender: M_____ F_____

VA Claim # _____ Social Security Number _____

Marital Status _____ Spouse's Name _____

Current Address _____
(Street) (City) (State) (Zip Code)

Email Address _____

Home Phone _____Other Phone _____

Present Location of Applicant: Home___ Hospital____ Nursing Facility____ Other____

Current Address *(If applicant resides other than at home, please provide the name, address and telephone number of the hospital, nursing facility or other location. Please insert on the line below.)*

_____

Primary Responsible Party *(party who handles applicant's financial and/or medical affairs)*

Name _____ Relationship _____ Financial _____ Medical_____

Address _____

Home Phone _____Other Phone _____

Legal Relationship: Self___ Power of Attorney___ Legal Guardian___ Surrogate Decision Maker___

Secondary Responsible Party *(party who handles applicant's financial and/or medical affairs)*

Name _____ Relationship _____ Financial _____ Medical_____

Address _____

Home Phone _____ Other Phone _____

Legal Relationship: Self____ Power of Attorney___ Legal Guardian___ Surrogate Decision Maker___

MEDICAL INFORMATION: *This section must be completed (Mandatory)*

Primary Physician _____

Address _____

_____

Phone_____Fax_____

Is your physician willing to come to the VPRS to continue caring for you?

Yes_____ No_____

Diagnosis Requiring Services *(attach copy of medical records or fill out completely)*

_____

_____

_____

_____

_____

Other Pertinent Diagnosis _____

_____

_____

Current Medications

Name	Dosage	Frequency

(Continue on additional page, if necessary.)

Known Allergies _____

_____

Additional Information _____

_____

HEALTH INSURANCE INFORMATION: *We will accept copies of your medical cards front and back in place of completing this section*

Primary Medical

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

Secondary Medical

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

Dental Insurance

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

Other Health Insurance/Long-Term Care Insurance

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

MEDICARE INFORMATION

Do you have Medicare Part A? Yes_____ No_____

Do you have Medicare Part B? Yes_____ No_____

Do you have Medicare Part D? Yes_____ No_____

Do you have pharmacy coverage? Yes_____ No_____

Carrier _____

Address _____

Phone _____ Fax _____

Policy # _____ Group # _____

Name of Policyholder _____

MEDICAID INFORMATION

Member ID: _____

Issuer ID: _____

Date card Sent: _____

INCOME INFORMATION: *Please complete to the best of your knowledge*

Usual Occupation_____Date Last Employed _____

Last Employer

Name _____ *Address* _____ *Phone* _____

If applicant is receiving VA income benefits:

Service Connected (SC) Disability Pension
$_____per month

Service Connected Disability Rating by VA
_____%

Non-Service Connected (NSC) Pension
$_____per month

Aid and Attendance
$_____per month

House Bound
$_____per month

Monthly income *before* deductions

Social Security _____per month
Military Retirement $_____per month
Private Pension _____per month
Workers Compensation $_____per month
Other Income _____ per month

If monthly income is not enough to pay applicant's portion of costs, what other resources are available? *(checking, savings, investments, etc.)* RATES ARE SUBJECT TO CHANGE AT ANY TIME.

_____ _____

_____ _____

VETERANS SERVICE INFORMATION: *Please complete to the best of your knowledge*

Branch of Service _____
Type of Discharge _____
Date Entered _____
State/County of Entry _____
Date Discharged _____
Discharge Location _____
Texas Resident Since _____
Voter Registration County _____

X _____ _____

Signature of Applicant or Responsible Party **Date**

Interview Questions: *Please complete or application will be rejected*

1. Do you have a sleep apnea diagnosis and/or currently using a CPAP equipment?
   Yes or No (circle)

2. Have you ever been diagnosed with symptoms of insomnia? **Yes or No (circle)**

3. Have you ever been diagnosed with symptoms related to hoarding?
   Yes or No (circle)

4. Are you a registered gun owner or have any weapons in your possession?
   Yes or No (circle)

5. Are you currently in recovery? If so from what? **(Please explain)**:
   _____
   _____
   _____

6. Do you currently attend group or AA meetings? **Yes or No (circle)**
   What location(s) do you attend?
   _____
   _____
   _____

7. Do you have any issues with people from diverse backgrounds? **Yes or No (circle)**

Comments you'd like to share about yourself or situation:

_____
_____
_____
_____
_____
_____
_____
_____

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Please complete this form. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid without an authorized signature and date or if it has expired.

Resident Name: _____
Last First MI Previous Name, if any

DOB:_____SS#_____Phone: _____ _____
Home Cell

Resident Address: _____
Street City State Zip Code

I authorize_____to disclose to **Veterans Progress & Recovery Services**

Address: 7622 Boggess Rd. Houston Texas 77016
Street City State Zip Code

Phone: **832-781-3331** Fax: _____ Email: **veteransprogressandrecovery@gmail.com**

Covering the periods of healthcare from (date)_____to (date) _____

For the purpose of: **At the request of the Individual named above**
(If requested by the patient, state "At the request of the Individual")

Method of disclosure: ☐ Mail ☐ Verbal ☐ Pick Up ☐ Fax ☐ Email

The following information may be released: (ex. clinical summaries, lab reports, nurses' notes, or all medical records)

_____

I give specific authorization to disclose the following information as well as documents that contain reference to:

_____ Medical Records Requests
_____ Drug and alcohol abuse treatment records
_____ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying the facility in writing.

Completion of this authorization form will not affect my treatment, payments, or eligibility for benefits. As a patient, I have the right to access my clinical records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand the information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Unless revoked earlier, this authorization expires upon this date or event: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient (or Patient Representative) Authority of Representative to act for Patient

For Office Use: Identity Verified by _____