Volunteers of America Northern Rockies
Grant Per Diem Application

For Office Use Only

Is the Veteran actively enrolled in SSVF? Yes No Does the Veteran currently have a VASH Voucher? Yes No

Can the Veterans needs be met in 90 days? Yes No In not, why? _____

Based on the initial assessment, which model is most appropriate to enroll the Veteran in and why?

_____

_____

Date of First Contact: _____ Date of Interview: _____ Date of admission: _____

Time of admission: _____ Referral Agency or Person: _____

Email of referring agency or person: _____ Phone: _____

Volunteers of America Northern Rockies shall not discriminate because of race, color, religion, sex, disability, familial status, national origin, creed, marital status, age, and regardless of sexual orientation or gender identity of applicants and residents.

Veteran Information:

First Name: _____ Middle: _____ Last: _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic Race: _____

SSN: _____ DOB: _____ Age: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Children: Yes ☐ No ☐ If yes, list ages: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Branch of Service: _____ Type of Discharge: _____

Independence Hall Fax: 406-248-9918

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Income:

Sources of Income	Gross Monthly Income	Annual Gross Income
VA Service-Connected Disability	$	$
VA Non-Service-Connected Disability	$	$
Social Security Disability	$	$
Social Security Income	$	$
Social Security	$	$
Other Sources of Income	$	$
Total Amount	$	$

Employment History:

Name of Employer:	Dates of Employment:	Position:	Duties:

Highest Level of Education Completed: _____

Marketable Skills/Licenses/Certifications/Credentials: _____

_____

Substance Abuse History: No ☐ Yes ☐

If Yes: Alcohol ☐ Drugs ☐ Both ☐ Date Last Used: _____

***Treatment History:**

Facility Name	Date of Attendance	Nature of Discharge

***Psychological History: (Mental Health Diagnosis)**

Diagnosis:	Diagnosed By:	Date of Diagnosis:	Medications Prescribed:

Independence Hall Fax: 406-248-9918

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Are you currently taking all prescribed psychiatric medications? Yes ☐ No ☐

If no, explain: _____

Have you been prescribed any medications that you are not taking but should be? Yes ☐ No ☐

***Medical History: (Current Medical Conditions)**

Diagnosis	Diagnosed By	Date of Diagnosis	Medications Prescribed

Are you currently taking all prescribed medications? Yes ☐ No ☐

If no, explain: _____

Do you need assistance paying for your medication? Yes ☐ No ☐

Physician's Name: _____

Facility: _____ City: _____

Date for last medical appointment: _____ Reason: _____

Date of Last Physical: _____

Date of Last Hospitalization: _____ Reason: _____

***Legal Status:**

Are you a convicted felon? Yes ☐ No ☐ If yes, Explain: _____

_____

_____

Are you currently on Probation/Parole? Yes ☐ No ☐

If Yes, What Type? ISP ☐ Supervised ☐ Unsupervised ☐

Probation Agents Name (If applicable): _____

Are you a registered sex offender? Yes ☐ No ☐

If yes, Explain: _____

_____

_____

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Motivation for Admission to the facility:
Why have you applied for admission to the Volunteers of America Northern Rockies GPD Program?

_____

_____

_____

Volunteers of America's Grant Per Diem program is a ZERO tolerance facility, anyone entering the program must agree to the following prior to admittance:

- Safety measures for all residents begin with new residents submitting to urinalysis and/or breathalyzer tests upon entry. Additionally:
    - Weapons (as described in the client handbook) or pornography are not allowed at any time.
    - Upon admission, your personal belongings will be checked. Any contraband found will be turned over to staff for proper disposal or locked in storage until dismissal.
- All residents will be expected to keep rooms clean and free from hazardous items that pose a health or safety risk.
    - Staff may randomly choose to inspect a room at any time and reserves the right to enter any drawer, closet, or bag when doing so.
    - Chores will be assigned to everyone in Independence Hall ensuring a clean, safe environment.
    - Residents will be expected to cook their own meals and not leave rotten, hazardous food or beverage items in the food storage areas. FAILURE TO DO SO MAY RESULT IN DISCIPLINARY ACTIONS, INCLUDING DISMISSAL FROM THE PROGRAM.
    - No items containing alcohol will be permitted for cooking and will be disposed of if found.
- Residents enter the facility at their own risk.
    - Any personal property items stolen or damaged will be discussed with staff but are ultimately the resident's liability.
    - Any issues not covered but in question should be discussed with the Program Manager or VA GPD Liaison before a service agreement is signed.
- Failure to fully disclose Treatment History, Psychiatric History/Mental Health Diagnosis, Medical History, and Legal Status can result in your application being denied or discharge from the program if discovered after entry to the program.

I, (print name) _____ Agree to have any information beneficial to the successful completion of my program shared with the professional agencies that Independence Hall works with. (All information is considered confidential and only shared when the case manager finds it necessary for the completion of goals.)

I understand that I will be given the opportunity to review and sign a release of information regarding any of my shared information necessary to the completion of my goals and stay at Independence Hall.

Veteran's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Volunteers of America Northern Rockies

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Birth date: _____

Alias or other legal name: _____Last 4 of SSN: _____

Release to: Volunteers of America Northern Rockies Phone: 406-259-5368

Address: 710 Lake Elmo Dr. Billings, MT 59105 Fax: 406-248-9918

Please initial:

____ I **hereby request and authorize you to release to Volunteers of America Northern Rockies, the following types of information, which you have or may receive, pertaining to me.**

____ **I hereby authorize Volunteers of America Northern Rockies to release to you the specified information indicated below.**

Information may be released:		Length of Time Authorization is valid:	
_____	Written	_____	1 month
_____	Oral	_____	6 months
_____	Fax	_____x	1 year
		_____	Other – please specify
		_____	One Time for a Specific Purpose – please specify _____

INFORMATION TO BE RELEASED AND/OR OBTAINED:

____ Intake Letter
____ Collateral Information
____ Alcohol/Drug Test Results
____ Consultation Reports
____ Resident Status/Attendance
____ Discharge summary including Continuing Care referral
____ Financial Responsibility
____ Address and phone number upon discharge
____ Other specific information to include: _____

PURPOSE OF RELEASE:

____ To gain background/collateral information
____ To arrange transfer/Referral to other agency
____ To facilitate communication with family/friends
____ To comply with Conditions of employment
____ To comply with conditions of social services
____ To provide coordination of medical care
____ To comply with conditions of court commitment
____ To collect for services rendered
____ Other: _____

Our program will not base services or other benefits on your willingness to sign this consent. Refusal to sign will only be related to release of information. I further understand that I may revoke this authorization at any time with a written request.

PROBHIBITION OF REDISCLOSURE: This notice accompanies a disclosure of information concerning a client in Veteran Services, made to you with consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

_____ _____

Veteran Signature: Date

_____ _____

Printed Name of Client/Resident Witness Date

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: 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 Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is 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 the instructions, gather the necessary facts and fill out this form. 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 information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

VA Medical Center Fort Harrison
3867 Veterans Dr.
Fort Harrison, MT 59636

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Volunteers of American Northern Rockies
710 Lake Elmo Dr.
Billings, MT 59105

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☒ OTHER *(Please specify)* GPD Housing Information

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☒ LIST OF ACTIVE MEDICATIONS: _____

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

_____

☒ OTHER *(Describe)*: Information for GPD enrollment and a copy of the HOMES assessment

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

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 records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider'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.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): Once the individual is taken off the interest lost or 30 day after the individual is discharged from the GPD program

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

811 Drug and Alcohol Screening

POLICY

Alcoholic beverages and drugs are strictly prohibited in any Volunteers of America Northern Rockies programs. Upon admission, each resident will be required to complete substance abuse screening with negative test results. VOANR shall conduct regular and random alcohol screenings to test for the use of substances. Upon suspicion of drug abuse, you may be required to submit to a urinalysis; if one or both are positive, you may be referred to a higher level of care and asked to leave the program. Program leadership will communicate with the VA Liaison concerning infractions of this policy. Veterans who are enrolled in the program and who commit infraction(s) of this policy will be referred to the VA Liaison to determine the appropriate level of care.

PROCEDURE

Breathalyzer Screening

When administering the breathalyzer, every effort must be taken to protect the veteran's privacy and ensure a valid test. All current health, safety, and disinfecting policies with appropriate PPE are to be practiced.

The following procedure should be followed when breathalyzing a veteran:

1. Offer the veteran a private location to conduct the breathalyzer.

2. Inform the veteran about the reason for the breathalyzer.
    a. Admission to the Grant and Per Diem Program
    b. Regular random drug testing as requested by the Program Manager
    c. Suspected use by Volunteers of America Northern Rockies staff member
    d. Returning from a Pass
    e. Return from AWOL
    f. Late arrival at the facility

3. Make sure the breathalyzer is calibrated to .000 and is sanitized in front of the Veteran.

4. Remove the mouthpiece from sealed packaging and place the mouthpiece on the breathalyzer in front of the Veteran.

5. Offer the two options of administering the breathalyzer test to the veteran:

    a. Staff-administered, if we are conducting the testing, stand to the side of the Veteran and have the Veteran blow into the breathalyzer until the reading is completed.

    b. Self-administered, place breathalyzer unit on a table, step away. Let the client step to the table, blow into the breathalyzer, and place the unit back on the table. This method, plus gloves and other PPE, can mitigate the 6' distance.

6. Inform the Veteran of the results.

7. In the event of a positive screen, complete the positive screen report and place it in the Program Manager's mailbox.

8. Document the test and results in the Veteran's file.

NOTE: Sanitizing unit and hand washing should be completed after each use.

Residents may refuse to submit to a breathalyzer at any time. If they do, complete an incident report, and inform the Veteran that such refusal may result in a behavioral contract or their discharge from the facility. Contact Program Manager with information the Veteran refused a breathalyzer.

Drug Screening

There are several circumstances under which a veteran may be screened for drugs which include:

- Admission to the Grant and Per Diem Program
- Regular random drug testing as requested by the Program Director
- Suspected use by Volunteers of America Northern Rockies staff member
- Returning from a Pass
- Return from AWOL
- Late arrival at the facility

When administering a drug screen, every effort must be taken to protect the veteran's privacy and ensure a valid test. The staff member taking the sample must accompany the veteran to the appropriate restroom to guarantee that it is that veteran's sample. A same-gender staff person will perform observed drug screens.

The following procedure should be followed when conducting a drug screen:

1. Inform the veteran about the reason for the drug screen
2. Request that the veteran leave any bags, coats, or parcels outside of the restroom
3. Escort the veteran to the restroom where the sample is to be given
4. Always wear rubber gloves when administering a drug screen
5. Allow the veteran to witness the administering of the screen and dispose of the sample once the screen has been administered
6. Inform the veteran of the results
7. Make a photocopy of the readout, regardless of a positive or negative result, and place it in the Program Manager's mailbox
8. In the event of a positive test, complete the positive screen report and place it in the Program Manager's mailbox
9. Document the test and results in the veteran's file.

Residents may refuse to submit to a drug screen at any time. If they do, complete an incident report and inform the veteran that such refusal may result in their discharge from the facility.

Revision Date: April 9, 2013

812 Zero Tolerance Policy

POLICY

Understanding that residents bring with them a myriad of needs and issues, Volunteers of America Northern Rockies nevertheless takes a zero-tolerance policy toward those behaviors that pose a threat, either physically or mentally, to any individual, group, or property. Violations of the zero-tolerance policy by residents living in a

Volunteers of America Northern Rockies program may result in Immediate Discharge from the residential program without readmission rights.

PROCEDURE

Behaviors included under this policy include, but are not limited to, the following:

- Any drug or alcohol use on the premises
- Possession or use of intoxicants, alcoholic beverages, or paraphernalia on the premises
- Refusal to submit to urinary analysis or breathalyzer testing
- Disregard for other's personal space and safety
- Violation of curfew without legitimate cause
- Violation of visitation rules
- Tobacco use within the home
- Theft
- Possession or use of weapons (knives, guns, contraband)
- The threat of violence or actual violence
- Causing damage to property of inflicting harm to another person
- Creating a disturbance that jeopardizes the safety and security of other residents or staff
- Tampering with or attempting to open or break into a locker, storage area, vehicle, or office as well as a locking device, shut off valve, power switch, or any other device that affects normal operations of this facility
- Refusing or failing to obey instructions by any staff member during an emergency or drill
- Possession, use of, removal of, or tampering with materials deemed confidential
- Refusing a search
- Sexual acts within the facility or on the Volunteers of America Wyoming & Montana's grounds.
- Interfering with staff in the performance of their job duties, including being noncompliant with staff directives.
- Refusing to complete any court obligations, including community service, opening a savings account, and refusing to pay the service fee.

Volunteers of America Northern Rockies reserves the right to review the individual case to determine the appropriate action in keeping with the spirit of our mission to help those in need while acknowledging the zero-tolerance policy. Actions that can be taken include, but are not limited to, the following:

- Immediate discharge without readmission rights
- Discharge to a treatment program with the opportunity for readmission
- Development of a behavioral contract to cover a period of no less than thirty days

By signing below, I have read or have had read to me the above; I have had any questions that I had answered to my satisfaction, I understand this document, and give my consent for searches of my vehicle, room, and property by Volunteers of America staff and law enforcement personnel.

Veterans Signature: _____ Date: _____

Staff Signature: _____ Date: _____