SOLDIER ON

The Fight Doesn't End When They Get Home

Referral/Level of Care Assessment Form

(Part 1)

Referring Agency_____**Date**_____

Referring Person_____**Telephone # (___)** _____

Veteran's Name_____**SS#**_____

DOB _____ **Previous Admission to Soldier On?** ☐**Yes** ☐**No Date**_____

Branch of Service _____ **DD214** ☐**Yes** ☐**No**
Discharge Status_____ **VA Eligible?** ☐**Yes** ☐**No**

Court Involvement_____**Charges**_____
Court/PO_____ **Date of Next Appearance**_____

Is the Prospective Resident Legally Competent? ☐**Yes** ☐**No**
Is there a Health Proxy in place? ☐**Yes** ☐**No**
Name_____**Contact #**_____

Does Prospective Resident have a history with Arson? ☐**Yes** ☐**No**
Suicidal Ideation? ☐**Yes** ☐**No** **History of Violence:** ☐**Yes** ☐**No** _____
_____
Has Prospective Resident ever been charged or convicted of a Sexual Offense? ☐**Yes** ☐**No**
(If yes acceptance criteria must be followed) Explain:_____
_____
_____

Substance Abuse History: Engaged in Treatment?_____ _____
Primary Drug of Choice: _____**Last drink/drug use :**_____
Is Prospective Resident scheduled to enter a substance abuse treatment program? ☐**Yes** ☐**No**
If yes Where & When_____
Is Prospective Resident involved in a methadone maintenance program? ☐**Yes** ☐**No**
If yes Where & When_____

Health Insurance? ☐**Yes** ☐**No** **Provider**_____
Medical Issues: ☐**Yes** ☐**No** _____
Medical Diagnosis:_____
Medications for Medical Issues: _____
_____
Medical Information:_____
_____
_____

Mental Health Issues ☐ Yes ☐ No Diagnosis:_____
_____
_____
Medications for Mental Health Issues: _____
_____
_____
Psychiatric Hospitalizations:_____
_____
_____

Occupation: _____ **Date last worked:** _____
Income Source:_____ _____**Amount: $**_____
Marital Status: _____ **Spouse Name:**_____
Children: _____ _____
_____
Family Involvement/Positive Supports:_____
_____
_____
_____

Please provide a Brief Description of Referents Current Needs (Including what has created need for housing, personal needs, strengths, any information that can assist Soldier On in determining eligibility:_____
_____
_____
_____
_____
_____
_____
_____
_____

UPON ADMISSION PROSPECTIVE RESIDENT WITH NEED TO HAVE THE FOLLOWING DOCUMENTATION:

***DD2-14**
***BIRTH CERTIFICATE**
***DRIVERS LISCENCE/ VALID IDENTIFICATION**
***SOCIAL SECURITY CARD**
***2 WEEKS OF MEDICATION FOR ALL PSYCHIATRIC AND MEDICAL NEEDS**
***PSY/SOCIAL REPORT FROM REFERRAL SOURCE**
***HEALTH CARE PROXY (IF ONE IN PLACE)**

SOLDIER ON

The Fight Doesn't End When They Get Home

Referral/Level of Care Assessment Form

(Part 2)

Basic Information

Prospective Resident's Name:_____

Age:_____ ☐Male ☐Female **Height**_____ **Weight**_____

Activities of Daily Living

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			
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 information such as 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;_____

_____

_____

_____

Signature of Person Completing this form:

_____

Name **Contact #**

Return completed form to: Soldier On, Intake Coordinator. Fax # 1-413-582-3021

Soldier On Women's Program

APPLICATION

Last Name_____First_____Middle Initial_____

Social Security No. _____D.O.B. _____/_____/_____

Current Address _____ Phone No. ( )_____

_____ Cell Phone No.( )_____

The race and ethnicity information on this form is required **for statistical purposes only** by the U.S. Department of Housing and Urban Development (HUD) to ensure non-discrimination in the program.

Race

☐ White ☐ American Indian/Alaska Native ☐ Asian

☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Income

Do You Receive Any Of The Following?

**Please answer yes or no to all questions below and provide $ amounts for those items checked YES. Do not leave any question blank.*

Employment Income Employer _____	☐Yes	☐No	Amount $/Month_____
VA Pension	☐Yes	☐No	Amount $/Month_____
Chapter 115	☐Yes	☐No	Amount $/Month_____
Public Assistance	☐Yes	☐No	Amount $/Month_____
Social Security	☐Yes	☐No	Amount $/Month_____
Social Security Disability	☐Yes	☐No	Amount $/Month_____
Settlement from Workers' Comp.	☐Yes	☐No	Amount $/Month_____
Settlement from Insurance Claim	☐Yes	☐No	Amount $/Month_____
Unemployment Benefits	☐Yes	☐No	Amount $/Month_____
Other Income	☐Yes	☐No	Amount $/Month_____

Total Annual Income $_____

Signature of Applicant_____ Date _____