

## VETERANS INC. APPLICATION FOR SERVICES

TELEPHONE: (508) 791-1213 ~ FAX: (888) 854-0853

VA EL \_\_\_\_\_; A \_\_\_\_\_; S \_\_\_\_\_; DVA RI \_\_\_\_\_; DD214 \_\_\_\_\_; FS \_\_\_\_\_; MA.H \_\_\_\_\_ CORI \_\_\_\_\_

**DATE OF APPLICATION** \_\_\_\_\_ (Referral \_\_\_\_\_; Walk-in \_\_\_\_\_; CHL Triage \_\_\_\_\_)

<b>Applicant's Name:</b>	Gender: M ___ F ___	SSN:	Tel #:	DOB:
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My #1. Most Urgent Need:	My 2 <sup>nd</sup> Most Urgent Need:	E-Mail Address:	Cell #:
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### REQUESTED SERVICE NEED(S) THIS DATE

Emergency or Temporary Shelter \_\_\_\_\_; Food Bank \_\_\_\_\_; Employment & Training \_\_\_\_\_; Transitional Housing \_\_\_\_\_; Mental Health Counsel \_\_\_\_\_; Substance Abuse Counsel \_\_\_\_\_; Benefits Info. \_\_\_\_\_; Case Management \_\_\_\_\_; Other \_\_\_\_\_ Please Specify:

### MILITARY SERVICE INFORMATION

**Do you have a DD214?** Yes \_\_\_\_\_; No \_\_\_\_\_    If Yes, is DD214 attached? Yes \_\_\_\_\_; No \_\_\_\_\_    If NO, Date sent for DD214: \_\_\_\_\_

**Branch of Service:** Army \_\_\_\_\_; Navy \_\_\_\_\_; Air Force \_\_\_\_\_; Marines \_\_\_\_\_; Coast Guard \_\_\_\_\_; Other(specify): \_\_\_\_\_

**Conflict:** WWII \_\_\_\_\_; Korea \_\_\_\_\_; Vietnam \_\_\_\_\_; Grenada \_\_\_\_\_; Panama \_\_\_\_\_; Persian Gulf \_\_\_\_\_; OEF \_\_\_\_\_; OIF \_\_\_\_\_

Dates Served: _____ to _____	Rank at Discharge:	MOS:	Combat Duty: Yes _____; No _____
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**Discharge Status:** Honorable \_\_\_\_\_; Other Than Honorable (OTH) \_\_\_\_\_; Dishonorable \_\_\_\_\_; General \_\_\_\_\_; Medical \_\_\_\_\_; Poor Conduct \_\_\_\_\_

Campaign Badge(s):	Honors &/or Citations:	Service Connected Disability? Yes _____ No _____	If Yes, Percent: _____%	Monthly Amnt: \$ _____
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### MONTHLY FINANCIAL ASSISTANCE OR COMPENSATION CURRENTLY RECEIVING

SCD:\$ _____	Chptr 115:\$ _____	Wkr's Comp:\$ _____	SSI: \$ _____	SSDI: \$ _____	Food Stamps:\$ _____	MTA:\$ _____	<b>Total:\$ _____</b>
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### GENERAL INTAKE INFORMATION

<b>If Referred, Name of CM, RN or Agent:</b>	Tel. #:	<b>Hosp./Program Name &amp; Admission Date:</b>
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<b>Hosp./Program Address:</b>	City:	State:	ZIP:
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<b>Your Home Address (or print "Homeless"):</b>	City:	State:	ZIP:
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If Homeless, How long?	How long in Household prior to being Homeless?	How long living in current Household?	Total family members in current Household?
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Own Home _____ Rent _____; Live w/ Other _____; Subsidized Housing _____	Household Ages: 0-4 _____; 5-17 _____; 18-64 _____; 65+ _____
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Marital Status: Single _____; Date Married _____; Date Separated _____; Date Divorced _____.	Date Widowed or Widower _____
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### EMERGENCY CONTACT

Contact's Name & Relationship:	Contact's TEL #:	Contact's E-Mail:
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### LEGAL & CORI INFORMATION

Have you been **Convicted** of: **ARSON** Yes \_\_\_\_\_; No \_\_\_\_\_; Any **SEXUAL OFFENSE**: Yes \_\_\_\_\_; No \_\_\_\_\_; Any **FELONY**: Yes \_\_\_\_\_; No \_\_\_\_\_?

List all Pending Charges, Warrants, Probation, Paroles (include Courts and Dates):	Longest Time Incarcerated?
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**EMPLOYMENT & TRAINING**  
(See US DOL Glossary of Terms for Definitions)

Education: 1-8 \_\_\_ 9-12 \_\_\_ HS Diploma \_\_\_ Voc. School \_\_\_ GED \_\_\_ Some College \_\_\_ Assoc. Degree \_\_\_ College Degree(s):

Current LIC.'s or Certs. Held:	Special Skills Held:	Last Stand Down Attended Where and When?
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Mental Health Conditions which could effect job selection: Chronic MI ___; MR ___; DD ___.	Physical Conditions which could effect job selection:
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Employment Status: Employed \_\_\_; Unemployed \_\_\_; Laid-off \_\_\_; Disabled \_\_\_ Retired \_\_\_ Current Yearly Income: \$ \_\_\_\_\_

**EMPLOYMENT HISTORY**

Job Title	Employer's Name & Address	Date Started -- Date Ended	Wage Earned

DESIRED Licenses, Certifications or Training: Tech/IT \_\_\_ CSL \_\_\_ CDL \_\_\_ Green Training \_\_\_ Other:

DESIRED Career Areas: Tech/IT \_\_\_ Construction \_\_\_ Commercial Driving \_\_\_ Green Jobs \_\_\_ Other:

**EMERGENCY SHELTER & TRANSITIONAL HOUSING**

(Check each Program for which you are applying)

**Grove Street Shelter \_\_\_ ; Cambridge/Canterbury Street \_\_\_ ; Devens \_\_\_.**

**Independence Hall \_\_\_ ; Sheridan House Women & Family Center \_\_\_ ; Bradford, VT \_\_\_.**

Have you prior residency at any Veterans Inc. (formerly MVI) Residences? Yes \_\_\_; No \_\_\_. If Yes, where & when?

Date applied for VASH ___; SEC. 8 ___. I Have NOT applied for either ___.	Why Veterans Inc. and Why Now?
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Short Term Immediate Needs & Goals:	Long Term Goals:
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Health Ins.	Primary Care Phys.	PCP Tel. #:	Date of Last TB Test & Documented Results:
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List Medical Condition(s) & Meds. for each (attach complete list):

Allergies:	Have you ever attempted SUICIDE? Yes ___ No ___ When? Explain:
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Most Recent Mental Health TX, Where & when? List Diagnoses & Meds. (attach complete list):

Last Substance Abuse DETOX or Rehab. – Where & When?	Drug(s) of Choice:	Longest Sobriety, When & How Long?	Are you taking Suboxone?
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Expected Date of Admission:	Do you have a valid Mass. Driver's LIC.?	Will you be bringing a Registered & Insured Vehicle:?
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**CONFIDENTIALITY & LIMITED LIABILITY STATEMENT**

I understand that the information provided on this form is private, and shall be held in strict confidentiality. I also agree that all the information above is correct to the best of my knowledge and hold harmless Veterans Inc., its Directors, and Employees from any liability, loss, claim, cost or damage of any nature, while receiving food from the Feed the Vets Program and/or participating in any program activity while at Veterans Inc.

Applicant's Signature:	Date:
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