



## Referral Form - Veteran Housing Programs

Hope for Veterans - Alfred J. Thomas - Women's Veteran Housing

Please complete all sections within the referral form. Do not leave any sections blank – utilize none or n/a as needed. Incomplete applications may delay the admissions process.

<b>Send Referrals via:</b>	<b>FAX:</b> (908) 647-9013 - ATTN: Admissions Planner	<b>MAIL:</b> Community Hope, Inc
	<b>E-MAIL:</b> <a href="mailto:VeteranHousing@communityhope-nj.org">VeteranHousing@communityhope-nj.org</a>	ATTN: Admissions Planner
	<b>For more information please call:</b>	151 Knollcroft Road, Bldg 53
	<b>Phone:</b> (201) 643-7799	Lyons, NJ 07939

### Referral Source Information

Date: \_\_\_\_\_ Referral Source Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to Veteran: \_\_\_\_\_

*Check here if authorization is given to add referral source information to Community Hope mailing list.*

Referral Source e-mail address: \_\_\_\_\_

Referral Source Type (Please Check One):

- |                    |                                  |   |
|--------------------|----------------------------------|---|
| Self-Referral      | CORE Residential – Lyons VA      | VA Medical – EOVA                               |
| Family Member      | Acute Psych – Lyons VA           | Community Based Outpatient Clinic               |
| Community Provider | Acute Psych – EOVA               | Women's Trauma Unit – Lyons                     |
| Shelter            | Acute Psych – Community Hospital | Domiciliary – Lyons VA                          |
| PTSD Unit – Lyons  | Domiciliary – Other VA           | Residential Substance Abuse Unit – EOVA         |
| Peer               | Homeless Outreach                | Supportive Services for Veteran Families (SSVF) |
| Other: _____       |                                  | VA Health Care for Homeless Veterans (VA HCHV)  |

### Demographic Information

Veteran Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Gender/Gender Identity: \_\_\_\_\_ Marital Status: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

SSN: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Insurance # (Medicaid/VA Pension #): \_\_\_\_\_





**Eligibility Information**

Current Housing Arrangements:

---

---

---

County of Origin (prior to hospitalization/ domiciliary admission):

---

Describe any current stable housing plan/time-frame:

---

---

---

Income Source & Amount: \_\_\_\_\_

Military History: \_\_\_\_\_

**Veteran Discharge Status (Please Check One):**

- |                        |                                |                               |
|------------------------|--------------------------------|-------------------------------|
| Honorable Discharge    | General Discharge              | Entry Level Separation        |
| Medical Discharge      | Other than Honorable Discharge |                               |
| Dishonorable Discharge | Bad Conduct Discharge          | Dismissal (Officer Discharge) |

*For Dishonorable Discharge, Bad Conduct, or Dismissal please provide additional information about the nature of discharge limited to content needed to determine program eligibility (such as: court-marshal, non-judicial punishment etc.):*

---

---

Psychiatric Treatment (Include History, At-Risk Behavior, etc.):

---

---

---

Diagnosis: \_\_\_\_\_

Medication Conditions/Diagnosis:

---

Medications & Prescribing MD:

---





Substance Use/Abuse History & Treatment/Length of Sobriety:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Pending Charges/Court Date (describe here):  
 \_\_\_\_\_  
 \_\_\_\_\_

Megan's Law/Tier (if applicable): \_\_\_\_\_  
 On Probation/Parole: \_\_\_\_\_

Veteran is open to receiving case management and linkages to resources or service for the purpose of finding permanent housing and/or employment.

I certify that the information contained herein is accurate to the best of my knowledge.

\_\_\_\_\_  
 Signature of Individual Completing Form

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name

The following documents are **required** prior to prescreening:

Verification of Honorably Discharged Veterans Status (*Copy of DD214*)

Most recent medical records including current diagnoses and medication list (*30-90 days, if applicable*)

Most recent psychiatric treatment records including progress notes and current diagnoses (*30-90 days, if applicable*)

Most recent alcohol/substance abuse treatment records including progress notes and current diagnoses (*30-90 days, if applicable*)

Proof of Megan's Law status (*if applicable*)

The following documents are **required** prior to admission:

Completed Community Hope, Inc. Medical Certification Form (*GPD Programs only*)

Proof of monthly income (*if applicable*)

