COMMUNITY HOPE, INC.
Referral Form
Hope for Veterans

Please read and follow directions below carefully. Incomplete applications may delay the admissions process.

All information can be faxed to Attn: Carlos J. Maldonado Jr. – Admissions Planner
Fax: 908-647-9013 / Phone: 973-738-6608

Referral Form (Pages 1 – 2)

- Do not leave any section blank. If a section does not apply, write "N/A" or "none."
- Under psychiatric treatment and substance abuse history, please include diagnosis as appropriate

Community Hope Authorization (Page 3)

- Write initials next to all (X) items
- Sign/date bottom

Community Hope Medical Certification (Page 4)

- Form MUST be submitted PRIOR to admission, no substitutions will be accepted
- PPD test MUST be completed
- Must be Free of Flu Like Symptoms
- Must have a negative COVID test
- Physician/RN MUST include license number

VA Release of Information (Pages 5 – 7)

- Form must be handwritten with nothing crossed out
- Please print as clearly as possible
- Fill in last name/first name, last 4 of SSN, and DOB near top of BOTH pages.
- Sign/Date under "Patient Signature" near bottom of 2nd page.

Please Include Additional Information (as appropriate)

- List of currently prescribed medications
- Proof of Military Service (DD214)
- Most recent medical records including current diagnoses and medication list (30-90 days)
- Most recent psychiatric treatment records including updated 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)
- Proof of monthly income (if applicable)

COMMUNITY HOPE, INC.
Referral Form
Hope for Veterans

Date: _____ Caller's/Sender's Name: _____

Phone:_____ Relationship to Veteran: _____

☐ Check here, if authorization is given to add caller's/sender's information to Community Hope mailing list. Complete Mailing List Contact Information Form.

Referral Source Type: (Please Check One)

☐ Self-Referral	☐ CORE Residential – Lyons VA	☐ Medical - EOVA
☐ Family Member	☐ Acute Psych – Lyons VA	☐ Community Based Outpatient Clinic
☐ Community Provider	☐ Acute Psych - EOVA	☐ Women's Trauma Unit – Lyons VA
☐ Shelter	☐ Acute Psych – Community Hospital	☐ PTSD Unit – Lyons VA
☐ Domiciliary - Lyons VA	☐ Domiciliary – Other VA	☐ Residential Substance Abuse Unit - EOVA
		☐ VA - Other

Veteran Name/Preferred Name _____

Address: _____

Phone #: _____ Gender/Gender Identity: _____

D.O.B.: _____ Age:_____ Marital Status: _____ Social Security #: _____

Income Source & Amount: _____ Insurance # (Medicaid/VA Pension #): _____

Military History: _____

Veterans/ Discharge Status: ☐ Honorably Discharged ☐ General Under Honorable ☐ Dishonorably Discharged

Current Housing Arrangements: _____

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

Reason Referred: _____

_____

Psychiatric Treatment (Include history, At-Risk behavior, Diagnosis)_____

_____

_____

Diagnosis _____

_____

Medical Conditions: _____

_____

Medications & Prescribing MD: _____

_____

_____

Legal: ☐ Pending charges/court date _____

☐ Megan's Law/Tier _____ ☐ On probation/parole _____

COMMUNITY HOPE, INC.
Referral Form
Hope for Veterans

Personal Information (family, cultural, education, vocational, legal): _____

_____

_____

_____

Substance Use/Abuse History & Treatment/Length of Sobriety: _____

_____

_____

_____

Diagnosis _____

The following documents are **required** prior to prescreening to the Hope for Veterans Program:

- ☐ Verification of Honorably Discharged Veterans Status (Copy of DD214)
- ☐ Most recent medical records including current diagnoses and medication list (30-90 days)
- ☐ 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
- ☐ Proof of monthly income (if applicable)

FOR COMMUNITY HOPE USE ONLY (Plan of Action):

__ Pre-Admission Evaluation to be completed by _____ Evaluation Date_____

__ COVID Vaccine _____ No Vaccine Name: _____ Vaccine Dates: _____

__ Meets Intake Criteria – No Resources Available – Add to Referral List

__ Does Not Meet Intake Criteria – Follow Up Action Taken/Date _____

_____

FOR COMMUNITY HOPE USE ONLY (Reason for Ineligibility):

❑ Non-Psychiatric Diagnosis	☐ Veteran declined services	☐ Unable to meet Communication Needs
❑ Actively destructive or disruptive	☐ Unable to meet Medical needs	☐ Does not meet Veterans Criteria
❑ Actively Suicidal or Homicidal	☐ History of At-Risk behavior	☐ Does not meet Sobriety Criteria
❑ Veteran placed in alternative services		☐ Does not meet Homelessness Criteria

_____ _____ _____
Sender's Name (print) Sender's Signature Date

_____ _____ _____
Community Hope Employee Name (print) CH Employee Signature, Credentials & Title Date

COMMUNITY HOPE, INC.
Referral Form
Hope for Veterans
Authorization to Use or Disclose Protected Information

Veteran Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____ Veteran ID#: _____

Type of Authorization

☐ Obtain From ____ ☐ Release To ____

☐ Monthly Family Contact ____ ☐ Agency Mailings to Family ____

Type of information to be disclosed

☐ Medical/Physical Exam	____	☐ Academic Records	____	☐ Court Records	____
☐ Drug/Alcohol Treatment Records	____	☐ Employment Records	____	☐ Police Records	____
☐ Lab work	____	☐ Pay Stubs	____	☐ HIV Status	____
☐ Medical Test Results	____	☐ Supportive Employment Records	____	☐ Psychiatric Evaluation	____
☐ Medical Follow Up Information	____	☐ Medication Orders	____	☐ Progress Notes	____
☐ Verification of Financial Status	____	☐ Treatment/Service Plans	____		
☐ Benefit & Entitlement Information	____	☐ Child Study Team Evaluation	____		

Other: _____

Specific purpose or need for this information:

☐ Veteran request to release a copy of their record	____	☐ Communication with psychiatric treatment provider	____
☐ Agency request to previous treatment information	____	☐ Communication with medical treatment provider	____
☐ Involve family members in veteran's recovery	____	☐ Obtain or verify financial information	____
☐ Advocacy	____	☐ Linkage to services	____
☐ Securing and maintaining employment	____	☐ Securing benefits (i.e.: social security, social services, etc.)	____

Other: _____

Information to be shared with the following individual or organization:

Name: _____ Relation: _____

Address: _____

Phone#_____ Phone # 2: _____

I authorize this information to be faxed (when applicable) _____ ☐ Yes ☐ No Veteran Initials: _____

A reproduction of this authorization shall be considered as the original. I understand that by law, I do not have to release the information specified above. However, I do so voluntarily for the purpose specified above. I further understand that I may cancel this authorization for the release of information at any time unless this information has already been released in reliance upon this authorization. This authorization automatically expires 12 months from the date of signature unless otherwise specified.

This information is being disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient from making any further disclosure unless such further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such Federal rules. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse individuals.

Date authorization expires if less than 12 months from the date signed: _____ Veteran Initials: _____

_____ _____
Veteran Signature Date

_____ _____
Parent/Guardian Signature (as applicable) Date

_____ _____
Witness Signature, Title & Credentials Date

Cancellation Use Only Date of cancellation: _____

Reason for cancellation: _____

_____ _____
Veteran Signature Date

_____ _____
Parent/Guardian Signature (as applicable) Date

_____ _____
Witness Signature, Title & Credentials Date