The name of the waitlist I'm applying for is: _____

Some waitlists are closed: Before sending this application, check http://www.housingworks.net/ to see what is open

Office Only: Date/Time Stamp

You must answer every question on this application: respond to questions that are not applicable by writing "N/A".
Incomplete applications may be returned or discarded.

MAIL TO: (Allow 3 wks for response)

Your Name:_____

Long-Term Mailing Address (an address that may work for the next 3-5 years):

_____

City/State/Zip: _____

Phones: _____ _____

Email: _____

Do you have a **Social Security Number** (SSN)? ☐ Yes ☐ No *If "Yes" you must provide the SSN below.*

The **SSN** for the head of household is: _____

What is your **date of birth**? _____ What is your **gender**? _____

Race (white, black, asian, etc)? _____ **Also**: ☐ Hispanic or ☐ non-Hispanic?

What was your **mother's last name** when she was born? *Protects your privacy)*_____

How many people will be living in the unit? _____ people. What **unit size** are you seeking?_____BR

Describe your **Income Sources** (Employment, SSI, TAFDC etc.) _____

What is your family's **ANNUAL** income? $_____ (do NOT write *an hourly, weekly, or monthly amount!)*

☐ YES ☐ NO Do you **have a rental voucher** or some other form of regular rental assistance?

Specify: ☐ Section 8 ☐ MRVP ☐ AHVP ☐ Flex Funds

☐ YES ☐ NO Do you need a **wheelchair accessible unit** (or a "no-steps" unit)?

☐ YES ☐ NO Do you need reasonable accommodations, either during the application period or tenancy?

☐ YES ☐ NO Are you or any member of your household subject to a lifetime registration requirement under a State Sex Offender Registration program?

Priority Status: We may or may not be able to take your priority need into consideration, but it is helpful for us to know what those priorities are:_____

All About …
Veterans Affairs Supportive Housing Program (VASH)

What is HUD-VASH?

The VA Supportive Housing Program is a joint project of the Department of Veterans Affairs (VA) and the Department of Housing and Urban Development (HUD). VASH provides Section 8 HUD vouchers to homeless veterans with substance abuse and/or mental health issues, and or having a physical disability. The goal of the program is to transition veterans from homelessness to independent subsidized housing by providing supportive, community-based case management services.

Who's eligible?

To be eligible for HUD-VASH veterans must:

- Be currently homeless
- Be eligible for VHA medical benefits
- Have a substance abuse, mental illness or physical disability history
- Be clinically stabilized
- Be prepared to make a commitment to VASH case management

What is the admission/referral process?

Step 1: Veteran is referred to the Northampton VAMC HUD-VASH Program by completing referral packet.

Step 2: Veteran meets with HUD-VASH case manager for a pre-screening interview.

Step 3: If determined eligible, Veteran's application will be reviewed by the admissions committee for acceptance into the HUD-VASH Program.

Step 4: Veteran is notified of acceptance, deferral or denial. If deferred, conditions of deferral are outlined and a time limit for completion is set.

Step 5: Veteran is accepted into VASH and begins case management.

How do the Section 8 Vouchers work?

Once a veteran has evidenced stability with regards to substance abuse and / or mental health Issues and/or has met deferral criteria, the VASH Case Managers assist the veteran in taking the necessary steps to secure subsidized housing. The Section 8 voucher provides VASH participants with a rental subsidy that generally covers rent that exceeds 30% of the veteran's income.

How does the supportive case management work?

The veteran's involvement with VASH case management begins with an individualized treatment plan that is reviewed periodically. The VASH Case Manager maintains an active liaison relationship with the Public Housing Authorities, helps veterans with the Section 8 process, assists veterans in identifying available housing in the community, and acts as a representative to landlords interested in renting to veterans in the community. Most importantly, the case manager provides long-term support and intensive clinical care required to sustain formerly homeless veterans in housing.

For referrals or more information, contact Susan White, LICSW at 413-584-4040, ext. 2135

HUD-VASH Referral Packet

Please complete the attached forms and return to:

Northampton VAMC
421 N. Main St.
Leeds, MA 01053
Attn: Susan White, LICSW
Building 4L, Rm. S107

_____ HUD-VASH Application

_____ HUD-VASH Psychosocial Information and Referral Form (to be completed by referring party, primary mental health provider or medical provider)

_____ Signed Release of Information for each non-VA primary provider (please make copies as needed)

_____ Copy of veteran's birth certificate*

_____ Copy of veteran's DD214*

_____ Copy of veteran's social security card*

*These may be delivered at the time of the pre-screening interview. However, please be aware that a veteran can not be screened for admission into the HUD-VASH program until these documents have been received.

HUD-VASH Application

Veteran's Name: _____

SSN: _____ ____ _____ Date Of Birth: _____Date: _____

Is Veteran currently homeless? ☐ Yes ☐ No Homeless Since: _____

Number of incidents of homelessness over past three years: ___

Is Veteran currently receiving case management services for homelessness? ☐Yes☐No

Is Veteran currently utilizing the VA for Services? ☐ Yes ☐ No

Is Veteran willing to accept VASH case management? ☐ Yes ☐ No

Veteran has a substance abuse diagnosis ☐ Yes ☐ No
Veteran has a mental health diagnosis ☐ Yes ☐ No
Veteran has a physical disability ☐ Yes ☐ No

Sobriety Since: _____

☐ Has veteran ever been convicted for a sexual offense? ☐Yes ☐ No

Source(s) and Amount(s) of Income: (*If Veteran receives disability income, include the disability for which he or she receives this income)*

_____

Other Providers: _____

_____

_____

Contact Information: (Should veteran's contact information change, the veteran must contact Susan White at 413-584-4040 ext 2135. A veteran will be removed from the VASH waiting list if staff cannot locate him/her).

Address: _____

Phone: _____

Email: _____

Referrer's Name and Date:_____

Please send completed referral packet to Susan White, LICSW, Building 4-Lower Room S-107, 421 North Main St., VAMC Northampton, Leeds, MA 01053.

Please also include a copy of your DD214, a copy of your birth certificate, and a copy of your social security card.

HUD-VASH

Psychosocial Information and Referral Form

Veteran's Name/Last Four: _____/_____

Date: _____ Form completed by: _____

Current Living Situation/Circumstances:

History of Homelessness (Length, places stayed, how became homeless):

Mental Health Diagnosis/Issues/Symptoms (SI/HI, hallucinations, delusions, vegetative symptoms, mood swings, racing thoughts, history of trauma, etc.):

Substance Use History (Length of current sobriety, longest period of sobriety, first use, relapse pattern, etc.):

History of MH and SA treatment (ASAP, SATP, domiciliary program, REACH, shelter program, sober houses, IOP, outpatient treatment, etc. Please include dates/circumstances of inpatient psychiatric admissions, if applicable.):

Current Mental Health/Medical Providers:

Medical Problems:

Legal Problems (Parole, probation, previous convictions):

Employment History (Last employment, type of work, highest education, military jobs, desire to work, etc.):

Does veteran have daily structured activity? Yes No
Please Describe:

Financial Situation (Source(s) of income/amount): _____

_____

Does veteran have a financial conservator? Yes No
If yes, contact information:

Does veteran need debt counseling? Yes No

Social/Family Supports:

Does the referring provider recommend admission into HUD-VASH? Yes No

If no, does provider recommend deferred admission pending recommended treatment/ actions? Yes No

Recommended treatment/actions:

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: 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 the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. 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 systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. 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 Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it 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 instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

VAMC Northampton
421 N. Main Street Leeds, MA

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

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

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

Oral disclosure of relevant data obtained during Homeless Intake and gathered from local and remote VA data histories to determine eligibility/priority status for HUD-VASH program.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Facilitate screening process for admission into the HUD-VASH program.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

Valid for up to 2 years or until discharge from SO.

I understand that the VA health care practitioner'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.

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY