



STATE OF CONNECTICUT
DEPARTMENT OF VETERANS AFFAIRS
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

THOMAS J. SAADI
DVA COMMISSIONER

NANCY NAVARRETTA, M.A., LPC, NCC
DMHAS COMMISSIONER

VETERANS RECOVERY CENTER
287 West Street
Rocky Hill, Connecticut 06067

Application for the Veterans Recovery Program

- Submit a copy(s) of your "**DD FORM 214 - Certificate of Release or Discharge from Active Duty**" listing your place of entry and discharge, dates of entry and discharge, record of service, time lost, and character of service. If you served more than one period please submit a copy of *each* DD214 you have received.
- All applicants will be required to have an in person interview.
- Any applicant who has been denied admission has the right to appeal in writing to the Commissioner of DMHAS within 10 days of notification.

For questions concerning the application and/or the process for admissions to the Veterans Recovery Center, please call (860) 616-3832. An Application can be submitted on line, mailed or faxed to: (860) 616-3549. Mail applications to:

VRC Admissions Coordinator
Veterans Recovery Center
287 West Street
Rocky Hill, Connecticut 06067

PLEASE FILL OUT EACH SECTION COMPLETELY (PLEASE PRINT)

Section 1 – PERSONAL INFORMATION		
Last Name:	First Name:	Middle Name:
Other Name/s Used:	Maiden Name (if applicable)	
Social Security #:	/ /	Date of Birth: (mm/dd/yyyy)
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Current Marital Status: (Check one) <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

Place of Birth (City and State):		
Connecticut Resident From:		To
Home Address:		
City:	State:	Zip Code:
Home Phone: ()	Work Phone:	
Cell Phone: ()	E-mail Address	
Are You Currently Living at Your Home Address?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, where are you staying now?		
<input type="checkbox"/> Shelter <input type="checkbox"/> With Family/Friends <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Temporary Veteran Housing <input type="checkbox"/> Treatment Facility <input type="checkbox"/> Other (Explain below)		
What is your Race? (You may check more than one. Information is required for statistical purposes only.)		
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		
Are you Spanish, Hispanic, or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Section 2: EMERGENCY CONTACT(S)		
Name:	Relationship:	Phone #1 () Phone #2 ()
Name:	Relationship:	Phone #1 () Phone #2 ()
Name:	Relationship:	Phone #1 () Phone #2 ()

Section 3: HEALTH INSURANCE		
Are you enrolled in the VACT Healthcare system? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you covered by any other health insurance policies? <input type="checkbox"/> Yes <input type="checkbox"/> No		

If so, name of Policy Holder	Group Code
Policy #	

Section 4 - MILITARY SERVICE		
Were you issued more than one (1) DD214?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please provide copies
Do you have a VA service-connected disability rating and are receiving VA compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, what %
Amount		
What condition(s) are you service connected for? (Please explain)		

Section 5 – RECOVERY		
Are you currently attending a substance abuse treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Program:	
Date begun:		
Substances Used:	Approximate Date of Last Use: (Month/Year)	
Alcohol	<input type="checkbox"/> Y <input type="checkbox"/> N	
Marijuana	<input type="checkbox"/> Y <input type="checkbox"/> N	
Cocaine	<input type="checkbox"/> Y <input type="checkbox"/> N	
Hallucinogens	<input type="checkbox"/> Y <input type="checkbox"/> N	
Inhalants	<input type="checkbox"/> Y <input type="checkbox"/> N	
Opiates	<input type="checkbox"/> Y <input type="checkbox"/> N	
Amphetamines	<input type="checkbox"/> Y <input type="checkbox"/> N	
Barbiturates	<input type="checkbox"/> Y <input type="checkbox"/> N	
PCP	<input type="checkbox"/> Y <input type="checkbox"/> N	
Other (specify)	<input type="checkbox"/> Y <input type="checkbox"/> N	

Have you previously attended a program for drug or alcohol treatment?

Yes No

If Yes, When and Where?

Section 6 - EDUCATION				
High School Graduate		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, highest grade completed
GED		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Technical School	<input type="checkbox"/> Certificate	<input type="checkbox"/> Some College		<input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree
Are you currently enrolled in college?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of College:		Program of Study:		
Are you currently enrolled in a Vocational Training program?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of School:		Program of Study:		

Section 7 - EMPLOYMENT				
Are you currently employed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Name of Employer:				
Address:				
City:	State:	Zip Code:		
Job Title:				

Section 8 - LEGAL HISTORY				
Have you ever been convicted of a felony?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please complete below				

Felony Charge	Date of Conviction	Town	State

Have you been arrested for any offenses that have not yet been resolved in court?

Yes No (If Yes, please explain)

Are there any outstanding warrants for your arrest?

Yes No (If Yes, please explain)

Are you currently on Probation?

If Yes, what legal charge(s) are you on Probation for?

Yes No

Probation Officers Name:

Phone #

Are you currently on Parole?

If Yes, what legal charge(s) are you on Parole for?

Yes No

Parole Officers Name

Phone #

PLEASE SUBMIT A COPY OF YOUR CURRENT TERMS/CONDITIONS OF PROBATION/PAROLE

Section 9 - POWER OF ATTORNEY / CONSERVATORSHIP

Power of Attorney

Do You Have a Power of Attorney?

If Yes - Is this Appointment for:

Effective Date:

Yes No

Person Estate Both

If Yes, complete information below - enclose a copy of decree

Name:

Relationship Family Member

Friend Attorney

Address:

Apt #

City:

State

Zip Code

Phone #'s

Home Phone

Work Phone

Cell Phone

Fax #

Email Address

Conservatorship

Do You Have Someone Appointed as Your Conservator? If Yes - Is this Appointment for: Effective Date:
 Person Estate Both
 Yes No

If Yes, complete information below - enclose a copy of Decree

Name:	Relationship	<input type="checkbox"/> Family Member
	<input type="checkbox"/> Friend	<input type="checkbox"/> Attorney
Street:	Apt #	
City:	State	Zip Code
Phone #'s:	Home Phone	Work Phone
	Cell Phone	Fax #
Email Address:		

Section 10 – MEDICAL/HEALTH

Do you currently have any medical or health issues that you would like us to know about?

Yes No

If yes, please identify:

Are you currently on any medication? Yes No

If yes, please identify:

Name of medical provider (optional):

Referred by

**Contact
Name/Title**

Agency

