



**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 Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Marijuana Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Cocaine Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Hallucinogens Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Inhalants Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Opiates Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Amphetamines Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Barbiturates Y <input type="checkbox"/> N <input type="checkbox"/>	_____
PCP Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Other (specify) Y <input type="checkbox"/> N <input type="checkbox"/>	_____

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

Yes No

If Yes, When and Where?

Section 6 - EDUCATION

High School Graduate Yes No

If no, highest grade completed

GED Yes No

Technical School

Certificate

Some College

Associate Degree
 Bachelor's Degree
 Master's Degree

Are you currently enrolled in college? Yes No

Name of College:

Program of Study:

Are you currently enrolled in a Vocational Training program? Yes No

Name of School:

Program of Study:

Section 7 - EMPLOYMENT

Are you currently employed? Yes No

Full-time Part-time

Name of Employer:

Address:

City:

State:

Zip Code:

Job Title:

Section 8 - LEGAL HISTORY

Have you ever been convicted of a felony? Yes 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please explain)			
Are there any outstanding warrants for your arrest? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please explain)			
Are you currently on Probation?		If Yes, what legal charge(s) are you on Probation for?	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Probation Officers Name:		Phone #	
Are you currently on Parole?		If Yes, what legal charge(s) are you on Parole for?	
<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes - Is this Appointment for: <input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Both		Effective Date:
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
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes - Is this Appointment for: <input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Both	Effective Date:
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please identify:
Are you currently on any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please identify:
Name of medical provider (optional):

Referred by				
<table border="1"> <tr> <td>Contact Name/Title</td> <td></td> </tr> <tr> <td>Agency</td> <td></td> </tr> </table>	Contact Name/Title		Agency	
Contact Name/Title				
Agency				

