STATE OF CONNECTICUT

DEPARTMENT OF VETERANS AFFAIRS

287 West Street
Rocky Hill, Connecticut 06067

Thank you for your interest in the Connecticut Department of Veterans' Affairs Patriots' Landing Program.

In order to process your application in a timely fashion, please review and include all necessary information along with your completed application.

1.	Enclose a copy(s) of your DD FORM 214
2.	Proof of Connecticut (CT) Residency – Applicants must be official residents of the State of Connecticut. If your DD214 does not indicate that you deployed from or returned to a Connecticut address, please attach a copy of your Connecticut driver's license.
3.	Supporting Document Health and legal documents may be requested Copy of Medical/Health Insurance Cards (VA CT Health System Card, Medicare, Medicaid)
4.	An interview will be conducted by CT DVA and Chrysalis Center Inc. staff. Based on that interview, the veteran may be required to provide additional medical, behavioral health, or substance abuse information.
5.	Veterans and their family will be assigned a Case Manager from Chrysalis Center Inc. and will be expected to develop and follow an Individual Recovery plan (IRP) outlining the goals needing to be accomplished to obtain permanent subsidized, affordable or independent housing.
6.	**Houses are not handicapped accessible**

For questions concerning the application or application process for PATRIOT'S LANDING Program at Rocky Hill, please contact Michele White, Admissions Coordinator at (860) 616-3803.

Mail application to:

PATRIOTS' LANDING PROGRAM
ATTN: Michele White, Admissions Coordinator
Department of Veterans' Affairs
Residential Facility, 287 West Street, Bldg., Rocky Hill, CT 06067
Fax application to: (860) 616-3556

Connecticut Department of Veterans' Affairs Application for Admission
PATRIOTS' LANDING PROGRAM
Please Fill Out Each Section Completely (PRINT)

Received by:
Date:

Section 1 - PERSONAL DATA

Last Name		First Name		Initial	
Others Name/s used		Maiden Name (if applicable)			
Social Security #		Date of Birth (mm/dd/yyyy)		Gender: Male ☐ Female ☐	
Place of Birth (City and State)		Connecticut Resident	☐ Yes ☐ No	From	To
Home Address				Apt. No.	
City		State		Zip	
Phone Number(s)					
E-mail Address					

Where are you staying now?
☐ Shelter ☐ With Family/Friends ☐ Hotel/Motel ☐ Treatment Facility
☐ Temporary Veteran Housing

What is your race? (You may check more than one.) (Information is required for statistical purposes only.)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Spanish, Hispanic, or Latino?

In Case of Emergency, please contact:

Name	Phone Number 1	Phone Number 2	Relationship

What circumstances have contributed to your needing temporary housing?
☐ Financial ☐ Unemployment ☐ Eviction / Foreclosure
☐ Legal ☐ Divorce / Separation ☐ Medical ☐ Other

Please give a brief written explanation

Section 2 - FAMILY INFORMATION

Current Marital Status: (Check one)	☐ Married	☐ Never Married	☐ Separated	
	☐ Widowed	☐ Divorced	☐ Unknown	
If married please provide name of spouse	Spouse Name			

Please provide child(s) name	Age	Gender	Grade
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	

Name _____ Last 4 Digits of Social Security # _____

Section 3 - MILITARY SERVICE			
• Please provide a copy of your DD214			
Branch of Service (Please Check)	☐ Army ☐ Navy ☐ Marine Corp ☐ Air Force ☐ Coast Guard		
Date Entered Active Duty		Date of Separation	
Place of Entry		Place of Separation	
Character of Service (Please Check)	☐ Honorable ☐ Under Honorable Conditions ☐ Medical ☐ Other (Explain)		
Were you issued more than one DD214	☐ Yes ☐ No	If yes, please provide copies.	
Are you currently still serving in the National Guard or Reserves?	☐ Yes ☐ No		

Section 4 - FINANCIAL INFORMATION					
Please check and provide the current monthly income you receive from the sources below					
☐	FT/PT Employment	$	☐	Unemployment Benefits	$
☐	VA Svc. Connected Disability	$	☐	VA Non-Svc/Pension	$
☐	DoD Disability	$	☐	Ed Benefits/GI Bill/VRAP	$
☐	Social Security Disability	$	☐	Social Security Retirement	$
☐	Other	$			

Section 5 - EDUCATION			
High School Graduate ☐ Yes ☐ No	If no – Highest grade completed		
GED ☐ Yes ☐ No			
College (Please Check Below)	☐ Some College ☐ Associate Degree ☐ Bachelor's Degree ☐ Master Degree		
Are you currently enrolled in college?	☐ Yes ☐ No	Are you currently enrolled in a vocational training program?	☐ Yes ☐ No

Section 6 - EMPLOYMENT					
Are you currently employed?	☐ Yes ☐ No	☐ Full-time ☐ Part-time			
Name of Employer					
Address					
City		State		Zip Code	
Job Title				Pay Rate	
If you are not currently working, are you receiving or have you applied for unemployment benefits? ☐ Yes ☐ No	If yes – Current Weekly Amount	Have you met with a CT Dept. of Labor Veterans' Employment Counselor? ☐ Yes ☐ No			

Name _____ Last 4 Digits of Social Security # _____

Section 7 - HEALTH INFORMATION			
Insurance Information			
Are you enrolled in the VA CT Healthcare System?	☐ Yes ☐ No ☐ Not Sure		
Are you covered by any other health insurance policies?	☐ Yes ☐ No	Health Insurance Company's Name	
Name of Policy Holder:			
Policy Number:		Group Code:	

Section 8 - RECOVERY SUPPORT					
Are you currently attending a substance abuse program now?	☐ Yes ☐ No	Name of Program			
When did you start?	Date		When do you complete?	Date	
Are you interested in participating in our Recovery Support Services to assist you with your ongoing substance abuse recovery?	☐ Yes ☐ No				

Section 9 - LEGAL				
Are you or anyone else who will reside in the house registered on the State Sex Offender Registry	☐ Yes ☐ No			
Have you ever been convicted of a felony?	☐ Yes ☐ No			
If Yes, please complete below				
Felony Charge	Date of Conviction	Town	State	
Have you ever been incarcerated? ☐ Yes ☐ No If yes, please explain	When	Where	Length of Sentence	
Have you been arrested for any offenses that have not yet been resolved in Court?	☐ Yes ☐ No	Are there any outstanding warrants for your arrest?	☐ Yes ☐ No	(If yes to either question please explain)
Are you currently on probation or parole?	☐ Yes ☐ No	Legal charge(s) that you're on probation for		
Probation Or Parole Officers Name		Phone #		
***PLEASE PROVIDE A COPY OF YOUR CURRENT TERMS/CONDITIONS OF PROBATION/PAROLE				

Section 10 - POWER OF ATTORNEY / CONSERVATORSHIP			
Power of Attorney			
Do you have a Power of Attorney?	☐ Yes ☐ No	If yes - Is this Appointment for: ☐ Person ☐ Estate ☐ Both	Effective date:
Conservatorship			
Do you have someone appointed as your Conservator?	☐ Yes ☐ No	If yes - Is this Appointment for: ☐ Person ☐ Estate ☐ Both	Effective date:

STATE OF CONNECTICUT
DEPARTMENT OF VETERANS AFFAIRS
287 West Street
Rocky Hill, CT 06067
(860) 616-3600

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name	Case No.	Date of Birth	Social Security Number

I HEARBY AUTHORIZE THE DEPARTMENT OF VETERANS' AFFAIRS TO **OBTAIN** INFORMATION FROM:	I HEARBY AUTHORIZE THE DEPARTMENT OF VETERANS' AFFAIRS TO **RELEASE INFORMATION TO:**
Chrysalis Center, Inc. 255 Homestead Avenue Hartford, CT 06112	(Person or agency, address, city, state, Zip) Chrysalis Center, Inc. 255 Homestead Avenue Hartford, CT 06112

This form serves the dual purpose of a general authorization for the release of protected health information and a specific authorization for the release of information protected by state and federal confidentiality laws and regulations. The information to be released may contain information pertaining to psychiatric, psychological, drug and/or HIV or AIDS testing, diagnoses or treatment.
Unless otherwise revoked, this authorization will automatically expire on 6 months post discharge (6 months from the date this form is signed, or a specific date, event, or condition if so requested by the patient).

Specific Report(s) – check all that apply:

- ☐ Consultation
- ☐ Discharge Summary and Diagnosis
- ☐ EKG/EEG
- ☐ History & Physical
- ☐ Laboratory Report
- ☐ Pathology Report
- ☐ Progress Notes
- ☐ Radiology ☐ Report ☐ Films
- ☐ Other (specify) _____

Specific information to be disclosed:

- ☐ Copy of complete health records
- ☐ Substance Abuse
- ☐ Psychiatric/Psychosocial
- ☐ Immunization
- ☐ Physical Therapy
- ☐ Medical/Surgical
- ☐ Ongoing communication *(telephonic/written/faxed)**
- ☐ Other (specify) _____
- ☐ Other (specify)_____

Purpose or need for information requested:

Dates of treatment:

I understand my right to revoke this authorization at any time. Revocation must be made in writing to the Director of Health Information Management Services. I understand the revocation will not apply to information that has already been released in response to this authorization.
I understand authorizing the disclosure is voluntary. I need not sign this authorization to ensure treatment, payment or healthcare operations. I understand I may inspect or have copies made of the information to be used or disclosed as provided in federal regulations 42 CFR 164.524. I understand information once released from this facility may not be protected by federal confidentiality rules and carries with it the potential for an unauthorized re-disclosure. I understand there may be a 65-cent/page-copy fee charged with certain requests for my health information. If I have questions about disclosures of my health information, I can contact the Health Information Management Services (HIMS).

Signature of Patient or Authorized Legal Representative *(State Relationship To Patient If Not Signed By Patient)* Date

Reason for signature if other than patient Signature of Witness Date

MAIL/FAX TO THE ATTENTION OF: *HEALTH INFORMATION MANAGEMENT SERVICES, DEPARTMENT OF VETERANS AFFAIRS, 287 WEST STREET, ROCKY HILL, CT 06067-3501* PHONE: (860) 616-3600 FAX: (860) 616-3556
H-110 Rev. 02/2014 **(Health care providers, individual patients only)*

STATE OF CONNECTICUT
DEPARTMENT OF VETERANS AFFAIRS
287 West Street
Rocky Hill, CT 06067
(860) 616-3600

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name	Case No.	Date of Birth	Social Security Number

I HEARBY AUTHORIZE THE SATE OF CT DEPARTMENT OF VETERANS' AFFAIRS TO **OBTAIN** INFORMATION FROM: (Person or agency, address, city, state, Zip)	I HEARBY AUTHORIZE THE STATE OF CT DEPARTMENT OF VETERANS' AFFAIRS TO **RELEASE INFORMATION TO:** (Person or agency, address, city, state, Zip)
VA CT Healthcare System	VA CT Healthcare System
555 Willard Avenue	555 Willard Avenue
Newington, CT 06111	Newington, CT 06111
950 Campbell Avenue	950 Campbell Avenue
West Haven, CT 06516	West Haven, CT 06516

This form serves the dual purpose of a general authorization for the release of protected health information and a specific authorization for the release of information protected by state and federal confidentiality laws and regulations. The information to be released may contain information pertaining to psychiatric, psychological, drug and/or HIV or AIDS testing, diagnoses or treatment.
Unless otherwise revoked, this authorization will automatically expire on _____or upon discharge from Patriots' Landing Temporary Housing Program (6 months from the date this form is signed, or a specific date, event, or condition if so requested by the patient).

Specific Report(s) – check all that apply:

- ☐ Consultation
- ☐ Discharge Summary and Diagnosis
- ☐ EKG/EEG
- ☐ History & Physical
- ☐ Laboratory Report
- ☐ Pathology Report
- ☐ Progress Notes
- ☐ Radiology ☐ Report ☐ Films
- ☐ Other (specify) _____

Specific information to be disclosed:

- ☐ Copy of complete health records
- ☐ Substance Abuse
- ☐ Psychiatric/Psychosocial
- ☐ Immunization
- ☐ Physical Therapy
- ☐ Medical/Surgical
- ☐ Ongoing communication *(telephonic/written/faxed)**
- ☐ Other (specify) _____
- ☐ Other (specify)_____

Purpose or need for information requested:

Dates of treatment:

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I understand authorizing the disclosure is voluntary. I need not sign this authorization to ensure treatment, payment or healthcare operations. I understand I may inspect or have copies made of the information to be used or disclosed as provided in federal regulations 42 CFR 164.524. I understand information once released from this facility may not be protected by federal confidentiality rules and carries with it the potential for an unauthorized re-disclosure. I understand there may be a 65-cent/page-copy fee charged with certain requests for my health information. If I have questions about disclosures of my health information, I can contact the Health Information Management Services (HIMS).

Signature of Patient or Authorized Legal Representative *(State Relationship To Patient If Not Signed By Patient)* Date

Reason for signature if other than patient Signature of Witness Date

MAIL/FAX TO THE ATTENTION OF: *HEALTH INFORMATION MANAGEMENT SERVICES, DEPARTMENT OF VETERANS AFFAIRS, 287 WEST STREET, ROCKY HILL, CT 06067-3501* PHONE: (860) 616-3600 FAX: (860) 616-3556

H-110 Rev. 02/2014

(Health care providers, individual patients only)

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)

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

Department of Veterans' Affairs, 287 West Street, Rocky Hill, CT 06067

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)

Entire record

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

Continuity of care

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):

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