

ARE YOU A HOMELESS VETERAN?

TRANSITIONAL VETERAN HOUSING PROGRAM AVAILABLE at Volunteers of America Mather Campus

Transitional housing program with offerings to assist veterans in increasing their income, moving into permanent housing, and accessing medical, dental, mental health, and other services



MODELS

Service Intensive Model: Veterans who want program based services and support.

Bridge Model: Veterans that have accepted permanent housing intervention (have in hand or are within 14 days of admission) through Supportive Services for Veteran Families (SSVF), Housing and Urban Development-VA Supported Housing (Hud-Vash), Housing Coalition/Continuum of Care (CoC, Housing Choice Voucher, SHRA, or similar.)

Low Demand Model: Veterans with multiple GPD stays, mental health, substance use challenges, previously unsuccessful in programs in the past.

WRAPAROUND SERVICES

- Temporary transitional housing
- Balanced meals
- Case management
- Assistance with accessing benefits
- Employment services
- Permanent housing search assistance
- Support addressing housing barriers
- Credit repair and financial literacy
- Community resourcing and linkage

ELIGIBILITY AND APPLICATION

Eligibility:

- There is no income required to apply or be accepted.
- 290's and Bad Conduct Discharge by General Court Martial are automatic disqualifiers.
- While the majority of the program serves individuals, couples (two person adult families) are assessed on a case by case basis for the Service Intensive and Bridge models of housing.

TO APPLY:

- Call (916) 515-7133 to request referral forms and applications.
- Completed forms can be emailed to: egarcia@voa-ncnn.org, faxed to 916-706-3457, or dropped off at the 10630 Schirra Ave, Mather CA 95655.



Veteran Application for Volunteers of America Grant and Per Diem Transitional Housing

Thank you for applying to Volunteers of America (VOA), Mather Campus, Grant and Per Diem (GPD) program. This program provides transitional housing services to Veterans experiencing homelessness. We are able to provide services to single men, women, and couples/families (two (2) person adult families).

Please answer the questions in this packet to help us determine whether or not you are eligible for GPD and how our program can best serve you. Please note that we must verify eligibility with the VA before enrolling an individual in our program as well as complete a background check. ***Having a 290 status will preclude applicants from acceptance into the program.***

In accordance with the Code of Federal Regulations “CFR” Volunteers of America has **Supportive Fees** in the amount of 30% of your adjusted gross income after HUD, VA, and Volunteers of America deductions and not to exceed the Fair Market Rate. We charge this to help form good tenant habits (responsibility, budgeting, and self-determination) for when you get housing and to help support the program. There is no minimum or maximum income to be accepted into the program.

You can submit this application in the following ways:

1. Fax it to 1 916-706-3457
2. Drop it off at our administrative office at 10630 Schirra Ave, Mather, California, 95655. We are open Monday through Friday 7:30am to 12:00pm and 1:00pm to 4:00pm.
3. Email directly to Elizabeth Garcia at: egarcia@voa-ncnn.org

If you any questions please call us at 916-515-7133

By signing below, you confirm that all information in this application is true and correct to the best of your knowledge. **You also authorize VOA to contact any other service provider named below for information that will help in providing you with services.**

Applicant Signature _____

Date: _____

FOR REFERRING AGENCY (If applicable-leave blank if you are the Veteran filling out this application for yourself):

1. Name of the person referring Veteran _____
2. Agency Name: _____
3. Agency telephone: _____



Veteran Application for Volunteers of America
Grant and Per Diem Transitional Housing

The Basics (for eligibility):

Name: _____

Phone Number: _____

Email Address: _____

Where are you living? _____

How long have you been there? _____

Social Security#: _____ - _____ - _____

Date of Birth: _____

Branch of Service _____

Dates Served: _____

Discharge Date: _____

Discharge Status: _____

1. How did you hear about our program? _____

2. *Monthly Income: _____ Source of Income: _____

*We charge a 30% supportive service fee on adjusted gross income (after HUD and our deductions, to help from good tenant habits), you do not need income to be accepted into the program.

3. Have you lived in a GPD (Grant and Per Diem) program before? [] Yes [] No

a. If yes, how many times? [] 1, [] 2, [] 3, [] 4+

b. When and where? _____

4. Have you ever been convicted by any court of an offense or have a record of convictions which took place in any state such as DUI, 290, violent offences? [] Yes** [] No

a. If yes, what was the conviction and in what year? _____

** Convictions for a violent offense within the last 3 years may disqualify you from this program. Convictions for a sex offense will disqualify you from this program. **

5. Do you have a current housing intervention such as HUD VASH voucher, SSVF, or Section 8? [] Yes [] No

a. If yes, please describe: _____

6. Are you able to live independently (wash, clothe, feed yourself?) [] Yes [] No

a. If no, please give details: _____



Veteran Application for Volunteers of America Grant and Per Diem Transitional Housing

Frequently Asked Questions (for understanding):

What Do We Do and How?

Applicant Initials _____

The purpose of our program is to support you in finding, securing, and keeping permanent housing. We do that by some of all of the following: case management to help work towards goals of needs and services, helping with credit repair, teaching skills for being a positive tenant/roommate, increasing income through employment coaching, resume building, benefit increase for service connected physical, mental health, military sexual trauma, and more.

Who Do We Partner With?

Applicant Initials _____

We work to connect you with the VA, Community and County service providers for dental care, medical care, mental health services, drug and alcohol services, and any other barriers or needs that you have that are unique to you.

Can I Bring My Service Animal?

Applicant Initials _____

We allow service animals on a case by case basis if they are *already* in your care. We do not allow you to obtain animals once in the program. We have a separate Service Animal Policy that must be adhered to.

Do I Have To Sleep There?

Applicant Initials _____

Grant and Per Diem is a federally funded program through Veterans Affairs that reimburses programs based on the number of nights Veterans sleep on the premises. Basically, once you're here you must sleep here in your bed every night unless you have a pre-approved pass that is related to your goals.

What About Drugs and Alcohol?

Applicant Initials _____

Mather is a clean and sober community; this is not just for your safety and protection but the safety and protection of other resident's sobriety. Struggling or using does not prevent with acceptance into the program.

I have read and understood the expectations and agreements needed for consideration for this program and wish to apply.

Applicant Signature _____

Date: _____



REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: 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 Act. 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 the instructions, gather the necessary facts and fill out this form. 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 the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA 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 system of records notices identified as 24VA10P2 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Address of VA Health Care Facility)

LAST NAME- FIRST NAME- MIDDLE INITIAL

LAST 4 SSN

DATE OF BIRTH

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

PURPOSE(S) OR NEED: Information is to be used by the individual for:

- TREATMENT BENEFITS LEGAL EMPLOYMENT OTHER (Please specify)

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

- HEALTH SUMMARY (Prior 2 Years)
INPATIENT DISCHARGE SUMMARY (Dates):
PROGRESS NOTES:
SPECIFIC CLINICS (Name & Date Range):
SPECIFIC PROVIDERS (Name & Date Range):
DATE RANGE:
OPERATIVE/CLINICAL PROCEDURES (Name & Date):
LAB RESULTS:
SPECIFIC TESTS (Name & Date):
DATE RANGE:
RADIOLOGY REPORTS (Name & Date):
LIST OF ACTIVE MEDICATIONS:
FLU VACCINATION (Dose, Lot Number, Date & Location):
OTHER (Describe):

LAST NAME- FIRST NAME- MIDDLE INITIAL		LAST 4 SSN	DATE OF BIRTH
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT. I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization. <input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE <input type="checkbox"/> SICKLE CELL ANEMIA <input type="checkbox"/> HUMAN IMMUNODEFICIENCY VIRUS (<i>HIV</i>) I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked <u>unless</u> I indicate by checking the box below that I do not want this information released for this specific disclosure. <input type="checkbox"/> I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.			
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 records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. I understand that the VA health care provider'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.			
EXPIRATION: Without my express revocation, the authorization will automatically expire. <input type="checkbox"/> AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED <input type="checkbox"/> ON _____ (<i>enter a future date other than date signed by patient</i>) <input type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): _____ _____			
PATIENT SIGNATURE (<i>Sign in ink</i>)		DATE (<i>mm/dd/yyyy</i>)	
LEGAL REPRESENTATIVE SIGNATURE (<i>if applicable</i>) (<i>Sign in ink</i>)		DATE (<i>mm/dd/yyyy</i>)	
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO PATIENT	
FOR VA USE ONLY			
TYPE AND EXTENT OF MATERIAL RELEASED			
DATE RELEASED		RELEASED BY:	