ROCK VALLEY COMMUNITY PROGRAMS, INC. Veterans Services Department
203 W. Sunny Lane Road, Janesville, WI 53546
PHONE: (608) 741-4500
WEBSITE: housing4ourvets.org
FAX: (608) 757-6410

Homeless Veterans Transitional Housing Program
Service Provider Referral for Services

Veteran's Information:		
Last Name:	First Name:	MI:
DOB:	Sex:	Race:
Phone #:	Social Security #:	
Additional Contact Phone #:		
Current Living Situation / Address:		
Email Address:		
Program/Treatment Needs: *(Please include substance abuse, mental health, medical, employment, education, etc. to the best of your knowledge)*		
Dates of Service:	State Entered Service:	
Type of Discharge:	DD214 Available:	
Do you have a valid driver's license?		
Have you ever applied to this program before?	If yes, Date of Application:	
Requested Dates / Duration:		
Date Placement is Needed:		
Anticipated Length of Stay:		
Transportation Needs for Arrival:		

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Referral Source:			
VA Hospital:	Self-Referral:	Homeless Shelter: Location:	HUD/VASH: Location:
Probation/Parole: Location:	Incarcerated Veteran Re-Entry Specialist:	CVSO County:	Other Specify:
Human Services: Location:	DAV: Location:	Dept. of Veterans Affairs: Location:	Prison: Specify:
Referral Source Name and Contact Information:			
Name and Title:			
Agency Name:			
Phone #:		Email Address:	
Referral Source Signature:			Date:
Sources of Income: *(Include all Wages, Unemployment, SSI, SSDI, Pension, etc.)*			
Source(s) 1.		Total Monthly Amount:	
2.		Total Monthly Amount:	
Applications for pension and/or disability pending?			
Filed by whom? Last date of contact with agency:			
Do you have a representative payee?		If yes, please provide the name and phone number for representative payee:	
Housing:			
Please give detail of circumstances leading to homelessness:			

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How long have you been homeless?		
Where are you currently living?		
Have you ever been evicted or asked to leave your residence for any reason?		
If yes, please explain:		
Previous RVCP Services:		
Have you ever received any service from RVCP?		
If yes, when?		
Health Issues / Have You Been Hospitalized?		
When was the last time you saw a doctor?		
Name of doctor and location:		
Current Medications:		
Physical limitations / restrictions / disabilities:		
Do you need a handicap accessible room?		
Have you ever been diagnosed with TB?	Do you have a history of positive skin tests?*	
***If yes, you must have a chest x-ray prior to entry.**		
Do you have health insurance?	If yes, what kind?	
Have you ever received medical care at a VA facility?		
Facility/Location:	Date(s):	Reason(s):

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Have you ever been involved in substance abuse treatment? Number of times: *Prior substance use / abuse will not result in non-acceptance into this program.*		
Facility / Location:	Date(s):	Reason(s):
Please list your drug(s) of choice, including alcohol:		
Are you currently using?	Last time used:	
Longest period of abstinence:		
Any problem with withdrawal? (Convulsions, DT's Seizures):		
Do you have any psychological or emotional issues such as depression, anxiety, PTSD or mental illness?		
Have you ever been hospitalized for mental health?		
Facility / Location:	Date(s):	Reason(s):
Criminal Justice Information (Required):		
Are you currently on Parole or Probation?	Date Supervision Ends:	
What State and County:		
Agent's name and phone #:		
List reason(s) for Parole / Probation (and all past criminal convictions): *Please note: Referrals for those from out of the Rock County area who are on probation / parole are required to be accepted by the Rock County Field office of the Wisconsin Department of Community Corrections Supervision. Upon acceptance by RVCP and the VA, the referral will be forwarded to the DOC for approval.*		

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Please describe any present legal issues:	
Any pending criminal charges:	If yes, describe:

Program Knowledge:

How did you find out about our program?
What is your main reason for wanting to come to this program?
Who may RVCP staff contact in the event of an emergency or if we are unable to reach you?

Name of Person(s):	Contact Phone #:	Email Address:

Authorization to Release Information:

I hereby consent to and authorize the release of information to the party or parties I have designated above as a person RVCP may contact to aid in communication between me and RVCP. The information authorized to be disclosed will be that only needed to make contact with me as needed by the RVCP Veteran Services Department to process my Application for Services. This information may include but is not limited to: Name, Eligibility Determination, and Requests for additional information needed by the program. I have given this consent voluntarily and I understand that authorizing this disclosure is not required in order to receive services. This Authorization will expire at the termination of my participation with RVCP Veterans Transitional Housing Program Application Process or at any time I request.

Veterans Initials: By initialing here I understand and agree to the Authorization to Release Information above.

(RVCP may not make contact with the listed parties without the Veteran's Initials)

The information provided in this application is complete and accurate to the best of my knowledge. I understand that any false or omitted information may cause my application to be delayed and/or me to be denied admission to the program.

Veteran's Signature:

Date:

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

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 information needed 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 the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 24VA10A7 "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 Location of the VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

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 requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

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

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ PATIENT MEDICAL RECORDS *(Dates)*: _____

☐ 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: _____

☐ VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☐ ADMINISTRATIVE RECORDS: _____

☐ OTHER *(Describe)*: _____

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

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.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

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 unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **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 *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 30 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Go to www.va.gov/health-care for information about VA health benefits.
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form:

- SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.
- COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.
- NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.
- TOXIC EXPOSURE RISK ACTIVITY (TERA): Veterans who were exposed to one or more of the following hazards or conditions during active duty, active duty for training, or inactive duty training (this is not an all-inclusive list): air pollutants, chemicals, occupational hazards, radiation, and warfare agents. For more information visit https://www.publichealth.va.gov/exposures/.
- NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.
- REPORTABLE INCOME: The minimum amount of gross income required to file a Federal income tax return according to the Internal Revenue Code of 1954 Section 6012(a).

Getting Started: ALL VETERANS MUST COMPLETE SECTIONS I - III.

Directions for Sections I - III:

Section I - General Information: Answer all questions.

Type of Benefit Applying For:

- **Enrollment -** Veterans applying for enrollment for the Full Medical Benefits Package provide in 38 C.F.R. 17.38 must meet the eligibility requirements of 38 C.F.R. 17.36.
- **Registration -** For Registrations, only complete Sections I, II, and III. Enrollment not required - Veterans requesting an eligibility assessment, clinical evaluation, care or treatment pursuant to a special treatment authority provided in 38 C.F.R. 17.37:
  - Care for a Veteran with a VA service connected disability rating of 50% or greater
  - Care for a VA rated service connected disability
  - Care for psychosis or other mental illness
  - Care for Military Sexual Trauma treatment (MST)
  - Catastrophically Disabled Examination
  - A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty can receive VA care for the 12-month period following discharge or release
  - Care for a Veteran participating in VA's vocational rehabilitation program under 38 U.S.C. 31

Section II - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If claiming a Military Exposure, you may provide us a written statement, or statements from people who witnessed your claimed exposure(s). If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

Section III - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

Directions for Sections IV-IX:

Section IV - Dependent Information: Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Section V - Employment Information:

- Veterans Employment Status
- Date of Retirement
- Company Name
- Company Address
- Company Phone Number

Section VI - Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those who served in a toxic exposure risk activity (TERA); or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in an Agent Orange exposure location; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children

Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI) and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payments; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

Section VIII - Previous Calendar Year Deductible Expenses

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report last illness and burial expenses, e.g., prepaid burial, paid by the Veteran for spouse or dependent(s).

Section IX - Consent to Copays and to Receive Communications

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

Submitting Your Application

1. You or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
2. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

Mail the original application and supporting materials to the Health Eligibility Center, PO Box 5207, Janesville, WI 53547-5207.

PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0091, and it expires 6/30/2024. Public reporting burden for this collection of information is estimated to average 35 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing this burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0091 in any correspondence. Do not send your completed VA Form 10-10EZ to this email address.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705,1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified from initial submission forward through a computer-matching program. 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 and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect 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.

OMB Control No. 2900-0091
Estimated Burden Avg. 35 min.
Expiration Date: 06/30/2024

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

VA DATE STAMP
(For VHA Use Only)

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

TYPE OF BENEFIT(S) APPLYING FOR:

☐ **ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)

☐ **REGISTRATION *(Complete Sections I, II, and III)*** - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU HISPANIC OR LATINO?
☐ MALE ☐ FEMALE	☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN ☐ TRANSGENDER WOMAN ☐ NON-BINARY ☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE	☐ YES ☐ NO

5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*	6. SOCIAL SECURITY NO.
☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ CHOOSE NOT TO ANSWER	

7A. DATE OF BIRTH *(mm/dd/yyyy)*	7B. PLACE OF BIRTH *(City and State)*	8. PREFERRED LANGUAGE	9. RELIGION

10A. MAILING ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

10F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)*	10G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)*	10H. E-MAIL ADDRESS *(optional)*

11A. HOME ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E.COUNTY

12. CURRENT MARITAL STATUS

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

13A. NEXT OF KIN NAME	13B. NEXT OF KIN ADDRESS	13C. NEXT OF KIN RELATIONSHIP

13D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14A. EMERGENCY CONTACT NAME	14B. EMERGENCY CONTACT TELEPHONE NO. *(Include Area Code)*

15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (*Note: This does not constitute a will or transfer of title*)

16. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*	17. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? ☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE *(mm/dd/yyyy)*	1C. FUTURE DISCHARGE DATE *(mm/dd/yyyy)*	1D. LAST DISCHARGE DATE *(mm/dd/yyyy)*

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION II - MILITARY SERVICE INFORMATION *(Continued)*

3. MILITARY EXPOSURE INFORMATION *(Check yes or no)*	YES	NO
A. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP? (*Hiroshima and Nagasaki cleanup or Enewetak Atoll, cleanup of Air Force B-52 bomber carrying nuclear weapons off the coast of Palomares, Spain, response to the fire onboard an Air Force B-52 bomber carrying nuclear weapons near Thule Air Force Base in Greenland.)*	☐	☐
B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS? *(Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, Yemen, Lebanon, Somalia, Afghanistan, Israel, Egypt, Turkey, Syria, Jordan, Djibouti, Uzbekistan, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, and the Red Sea.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE:*** *Please provide an approximate time-frame (mm/yyyy)* FROM: _____ TO: _____	☐	☐
C. WERE YOU DEPLOYED IN SUPPORT OF ANY OF THE FOLLOWING OPERATIONS? *(Enduring Freedom, Freedom's Sentinel, Iraqi Freedom, New Dawn, Inherent Resolve, and Resolute Support Mission)*	☐	☐

	YES	NO
D. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE *(e.g. Agent Orange)* LOCATIONS? *(Republic of Vietnam to include 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a c-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE:*** *Please provide an approximate time-frame (mm/yyyy)* FROM: TO:	☐	☐

E. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? *(Check all that apply)*
Veterans can locate additional military exposure categories on VA's Public Health website at: https://www.publichealth.va.gov/exposures/

- ☐ AIR POLLUTANTS *(burn pits, sand, oil well/sulfur fires)*
- ☐ CHEMICALS *(pesticides, herbicides, contaminated water)*
- ☐ CONTAMINATED WATER AT CAMP LEJEUNE
- ☐ RADIATION ☐ SHAD *(Shipboard Hazard and Defense)*
- ☐ OCCUPATIONAL HAZARDS *(jet fuel, industrial solvents, lead, firefighting foams)*
- ☐ ASBESTOS ☐ MUSTARD GAS
- ☐ WARFARE AGENTS *(nerve agents, chemical and biological weapons)*
- ☐ OTHER *(Specify)*:

WHEN WERE YOU EXPOSED?
NOTE: *Please provide an approximate time-frame (mm/yyyy)*
FROM: TO:

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal health insurance for low income adults)*	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	6B. EFFECTIVE DATE *(mm/dd/yyyy)*	6C. MEDICARE NUMBER:
☐ YES ☐ NO	☐ YES ☐ NO		

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*	2. CHILD'S NAME *(Last, First, Middle Name)*
1A. SPOUSE'S SOCIAL SECURITY NUMBER	2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)* / 2B. CHILD'S SOCIAL SECURITY NO.
1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

1C. SPOUSE'S SELF-IDENTIFIED GENDER IDENTITY
☐ MAN ☐ WOMAN ☐ TRANSGENDER MAN
☐ TRANSGENDER WOMAN ☐ NON-BINARY
☐ PREFER NOT TO ANSWER ☐ A GENDER NOT LISTED HERE

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*
☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

1D. DATE OF MARRIAGE *(mm/dd/yyyy)*

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?
☐ YES ☐ NO

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?
☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD WITH REPORTABLE INCOME FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?
☐ YES ☐ NO

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*.

☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED

1B. DATE OF RETIREMENT *(mm/dd/yyyy)*

1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

SECTION VI - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. Veterans who choose not to disclose financial information may not be eligible for enrollment or may be responsible for any applicable VA copayments, if they are enrolled. **Recent Combat Veterans (e.g., OEF/OIF/OND)** may answer YES in Section VI and complete Sections VII and VIII to have their priority for enrollment and financial eligibility for travel assistance, cost-free medications and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through VIII.** If I am enrolled, I agree to pay applicable VA copayments. Sign and date the form in the Assignment of Benefits section.

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable Sections VII and VIII. Sign and date the form in the Assignment of Benefits section.

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

(Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension, interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION IX - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT *(Sign in ink)* _____

DATE *(mm/dd/yyyy)* _____