Upstate Warrior Solution Warrior Profile

Today's Date:_____

Profile			
How did you hear about UWS?		**Social Security Number (last four):**	
Full Name (First, MI, Last):		**Phone Number:**	
Email Address:		**Date of Birth:**	
Gender: ◯ Female ◉ Male ◯ Transgender		**Race:**	
Marital Status ◯ Single ◯ Married ◉ Divorced ◯ Separated ◯ Widowed		**Kid(s) Age:**	**Household #:**
Address:			
City:	**State:**	**Zip:**	**County:**
Total Household Income: ◯ Under $25K ◯ $25K-$35K ◉ $35K-$45K ◯ $45K+ ◯ Decline to Answer			

Military Service			
Current Status: ◯ Still Active ◯ Discharged ◯ Medically Retired/Separated ◯ Retired			
Last/Current Rank/Pay Grade Held in Military:			
Service Dates (MM/DD/YY – MM/DD/YY):			
Were you ever deployed to a Combat Zone? ◯ Yes ◯ No **If so, where?**			
Branch of Service: ◯ Air Force ◯ Army ◯ Coast Guard ◯ Navy ◯ Marines			
Service Component: ◯ Active Duty ◯ National Guard ◯ Reserve			
Type of Discharge: ◯ Hon ◯ Gen ◯ OTH ◯ BCD ◯ DD ◯ Admin			

Warrior Background Summary (Military Occupational Specialty, overseas tours, split service dates, etc.)

Mode of Transportation ◯ Privately Owned Vehicle	◯ Public Transit	◯ Shared Transit	◯ Bicycle	◯ Uber/Lyft	◯ None	

Housing						
Current Living Conditions: ◯ Rent	◯ Own	◯ Treatment Facility	◯ Incarcerated	◯ Family/Friend	◯ Shelter	
Homeless: ◯ Yes ◯ No **Last Date Homeless:**			**Has valid driver's license:** ◯ Yes	◯ No		
Would you like UWS to contact you for housing assistance ◯ Yes ◯ No **Notes:**						

Employment					
Employment Status: ◯ Employed	◯ Unemployed	◯ Retired	◯ Unable to Work(SSD/IU)	◯ Other:	
Do you have a current resume? ◯ Yes ◯ No		Would you like assistance updating your resume? Yes ◯ No ◯			
If seeking, what types of employment interest you? (Top 3)					
If seeking, required minimum salary: (Hourly or Yearly) (Full-time or Part-time)					
Would you like UWS to contact you for employment assistance? Yes ◯ No ◯ **Notes:**					

If found please return to 3 Caledon Ct. Suite A-2, Greenville SC 29615

Education

Which education benefit are you eligible for?

Chapter 1606 NG/Reserve	Chapter 1607 REAP	Chapter 31 Voc. Rehab	Chapter 33 Post 9/11	Chapter 35 Survivor / DEA	Not Eligible for Benefit

Where are you enrolled in school? **Highest level of education completed:**

Would you like UWS to contact you for education assistance? Yes No **Notes:**

Healthcare and Benefits

Are you eligible for Tricare? Yes No **Enrolled in Tricare?** Yes No **Other Health Insurance?** Yes No

Are you eligible for VA Healthcare? Yes No **Enrolled in VA Healthcare?** Yes No

Are you enrolled in eBenefits? Yes No Not Sure **Do you have a Service-Connected Disability?** Yes No

Disability Percentage: **Combat-Related?** Yes No **Types of Injuries:**

Would you like UWS to contact you for healthcare and benefits assistance? Yes No **Notes:**

Support Programs

Are you interested in spouse/caregiver Family Support Programs? Yes No

Spouse/Caregiver Name: Email:

Phone: Anniversary Date: Spouse former member of the US military? Yes No

Are you interested in volunteering for Upstate Warrior Solution? Yes No

Are you interested in receiving recreation opportunities? Yes No

Warrior Questionnaire (Please select most applicable answer for each question)

1 – Strongly Agree; 2 – Agree; 3 – Unsure; 4 – Disagree; 5 – Strongly Disagree; 6 – Decline to answer

1. I am able to adapt when changes occur	1 ●	2	3	4	5	6
2. I feel supported by my community	1	2	3	4	5	6
3. I tend to bounce back after illness, injury, or other hardships	1	2	3	4	5	6

FOR INTERNAL USE ONLY

Education_____

Housing _____

Healthcare & Benefits_____

Employment_____

Volunteering_____

Family Support_____

NOTES

Release of Information

I request and authorize the release of the above information between Partner Portal agencies, other external agencies, and Upstate Warrior Solution. I certify that this request has been made voluntarily and without coercion. I may revoke this request at any time in writing by emailing info@upstatewarriorsolution.com. The purpose of this referral is for the coordination of care, services, and resources and can include both written, verbal information, as well as other records and information covered by HIPAA and other privacy laws. This form is intended to generate a referral, initiate services, and coordination of care between organizations to provide holistic support.

Sign:_____ **Date:**_____