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:**			
Are you currently a first responder? Yes No Type:			

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					
Spouse Gender: Female Male Transgender **Spouse Race:**					
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:**_____