

Upstate Warrior Solution Warrior Intake

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:	Male	Female	Other		Race:
Marital Status:	Single	Married	Divorced	Separated	Widowed
Number in 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
Do you want to be connected to Veterans ASCEND? 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:					

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
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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:**

Are you connected to mental health resources? Yes No

Do you want to be connected to mental health resources? Yes No

Emergency Contact

Name: **Phone Number:**

Address: **Relation:**

Support Programs

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

Spouse/Caregiver Name: **Email:**

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

Kids Names & Ages:

Is your spouse/caregiver interested in Family Services Programs? 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	2	3	4	5	6
1. I am able to adapt when changes occur						
2. I feel supported by my community						
3. I tend to bounce back after illness, injury, or other hardships						

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 community partners, other external agencies, and Upstate Warrior Solution. I also authorize UWS to contact my stated Emergency Contact in case of an emergency, such as suicidal or homicidal behavior. 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.org. 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:** _____