Upstate Warrior Solution Warrior Intake

Staff Initials:________ **Today's Date:____________**

Profile			
How did you hear about UWS?		**SSN:**	
Full Name (First, MI, Last):		**Phone Number:**	
Email:		**Date of Birth:**	
Gender: Male Female Other		**Race:**	
Marital Status: Single Married Divorced Separated Widowed		**# in Household:**	**# Kids:**
Address:			
City:	**State:**	**Zip:**	**County:**
Total Household Income: Under $25K $25K-$35K $35K-$45K $45K+			

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	Do you want to be connected to Veterans ASCEND? Yes No
If seeking, required minimum salary: (Hourly or Yearly) (Full-time or Part-time)	
If seeking, what types of employment interest you? (Top 3)	
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

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 VA.gov? 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

Are you connected to mental health resources? Yes No

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

Are you currently experiencing a mental health crisis? Yes No

Do you want assistance with a substance use disorder? Yes No

Notes:

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: Spouse former member of the US military? Yes No

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

Would you like to be connected with a church or chaplain? Yes No

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:**__________