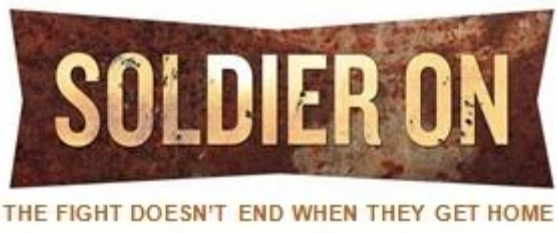


Referral/Level of Care Assessment Form

Referring Agency_____Date_____

Referring Person_____ Telephone # (_____) _____

Veteran's Name_____SS#_____

DOB _____Telephone # (_____) _____

Previous Admission to Soldier On? ☐Yes ☐No

Branch of Service _____ DD214 ☐Yes ☐No

Discharge Status _____ VA Eligible ☐Yes ☐No

Does Prospective Residents have an apartment or house in his/her name? ☐Yes ☐No

Court Involvement _____ Charges_____

Court/PO _____Date of Next Appearance _____

Is the Prospective Resident Legally Competent? ☐Yes ☐No

Is there a Health Proxy in place? ☐Yes ☐No
Name _____ Telephone # (_____) _____

Does Prospective Resident have a history of Arson? ☐Yes ☐No

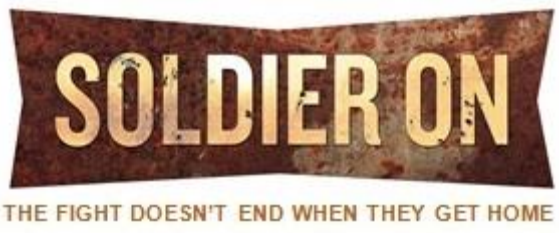
Suicidal Ideation? ☐Yes ☐No History of Violence? ☐Yes ☐No If yes, explain. _____

_____

Has Prospective Resident ever been charged or convicted with a Sexual Offense? ☐Yes ☐No
(If yes acceptance criteria must be followed) Explain: _____

_____

_____



Substance Abuse History: Engaged in Treatment?_____

Primary Drug of Choice _____**Last drink/drug use** _____

Is Prospective Resident scheduled to enter a substance abuse treatment program? ☐Yes ☐ No
If Yes, When & Where: _____

Is Prospective Resident involved in a methadone maintenance program? ☐Yes ☐ No
If Yes, When & Where: _____

Health Insurance ☐Yes ☐ No Provider: _____

Medical Issues: ☐Yes ☐ No _____

_____

_____

Medical Diagnosis:_____

_____

Medications for Medical Issues _____

_____

Medical Information _____

_____

Do you have a Medical Marijuana Card: ☐Yes ☐ No

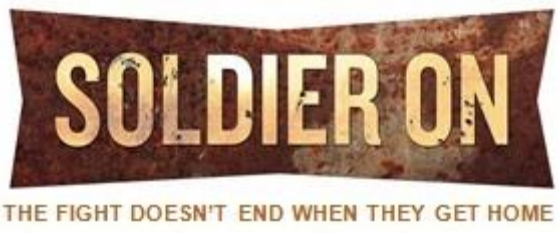
Mental Health Issues ☐Yes ☐ No
Diagnosis:_____

Medications for Mental Health Issues _____

_____

Psychiatric Hospitalization _____

_____



Occupation _____ Date last worked _____

Income Source _____Amount $_____

Marital Status _____ Spouse _____ _____

Children: _____

_____

Family Involvement/Positive Supports: _____

_____

_____

Please provide a brief description of Referents Current Needs (Including what has created a need for housing, personal needs, strengths, any information that can assist Soldier On in determining eligibility.

_____

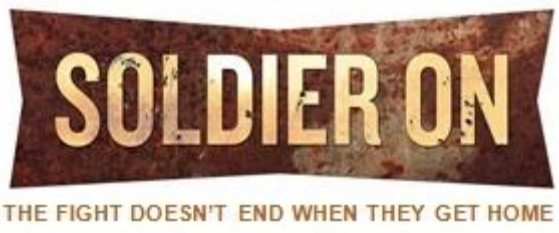
_____

_____

_____

_____

_____



Prospective Resident's Name:_____

Age:_____ **□Male □Female** **Height**_____ **Weight**_____

Activities of Daily Living

ADL General	No Help Needed (Independent)	Some Help Needed	Extensive Total Help
Dressing: Upper Body	□	□	□
Dressing: Lower Body	□	□	□
Hygiene: Hands, Face	□	□	□
Hygiene: Hair,Teeth,Shaving	□	□	□
Hygiene: Showering	□	□	□
Locomotion: Walking, Wheelchair	□	□	□
Dining: Set Up, Self Feeding	□	□	□
Mobility: In/Out Bed, Chair	□	□	□
Mobility	□ walker	□wheelchair	□both
Bowel/Bladder			
Bowel: Continence needs	□	□	□
Bladder: Incontinence needs	□	□	□
Mental/Cognitive Status			
Alert/Orientated (time, place person)	□Yes	□No	
Memory Loss (short term)	□Yes	□No	
Memory Loss (long term)	□Yes	□No	
Wanders	□Yes	□No	
Any challenging behaviors?*	□Yes	□No	

***This includes things like being disruptive, agitated, or aggressive, abusive, demanding, and/or requiring frequent staff interventions. Is this prospective resident delusional or has hallucinations? Please describe prospective resident's emotional status, personality, and demeanor;**_____

Signature of Person Completing this form:

_____

Return completed form to: Soldier On, Intake Coordinator. Fax # 1-413-582-3035