CARITAS communities | Preventing homelessness. Improving lives. One room at a time.

**You are applying for a Single Room Occupancy at the Bedford Veterans Quarters located at 200 Springs Rd, Building #5, Bedford, MA 01730,**

**Please be sure the attached application includes:**

- ☐ Caritas Application
- ☐ Waiver
- ☐ Bank Verification form – to be filled out by your bank. You instead submit your last 6 months of statements
- ☐ Affidavit of No Assets form – to be filled out only if you have no bank accounts.
- ☐ Under 5,000 Asset Certification
- ☐ Income Verification
    - Please have your employer fill out the attached employee verification form
    - Also include your last 2 months of paystubs
    - If you are receiving benefits (SSI, SSDI, EAEDC, unemployment, pension, etc) you must attach a copy of your benefits letter. The dated within the last 3 months.
- ☐ Declaration of 214 Status Form
- ☐ Drug And / Or Violent Criminal Activity Consent Form
- ☐ VA Releases
- ☐ MBHP Release
- ☐ Birth Certificate copy
- ☐ DD-214 copy (discharge form)
- ☐ Photo ID
- ☐ Social Security Card
- ☐ VA card
- ☐ Written proof of homelessness
- ☐ Pharmacy printout of current medications

**The following is required in order to be considered for housing:**

- Ability to pass CORI
- Income under the Section 8 limit ($34,250/yr)
- Sober/Clean for 120 days (be aware that random breathalyzer, blood draw, and urinalysis can and will be conducted during your tenancy, no alcohol, non-prescribed drugs or tobacco will be tolerated.

**If you have any questions please call Eddie Currier 781-275-6296 or email ecurrier@veteranbenefits.us**

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*Revised March 2016*

# BEDFORD VA HOUSING APPLICATION

| Name: | DOB: | Social Security No: |
|---|---|---|
| Full Address: | | |
| Day Phone: | Cell: | Email: |

| | |
|---|---|
| Are you a convicted Sex Offender? ☐ Yes ☐ No *Circle Level/Status:* 1 2 3 Pending | |
| Do you have a history of illegal drug use? *If yes attach description* | ☐ Yes ☐ No |
| Have you ever been convicted of a felony? *If yes attach description* | ☐ Yes ☐ No |
| Have you ever been evicted from any housing? *If yes attach description* | ☐ Yes ☐ No |
| Will you be in the next year / have you been in the last 5 months a full-time student? | ☐ Yes ☐ No |
| Are you currently homeless or have you been homeless in the past (6) months? | ☐ Yes ☐ No |

| **Source of Income** | **Gross Monthly Income** | **Do you expect a change in the next 12 months? Why?** |
|---|---|---|
| Employment | $ | |
| SSI/SSDI Benefits | $ | |
| Pension or Retirement | $ | |
| Veteran's Benefits | $ | |
| Unemployment | $ | |
| Other - explain | $ | |

| | |
|---|---|
| Do currently work for the VA CWT or CCT programs ☐ Yes ☐ No | If so which? |
| Do You have a Representative Payee? ☐ Yes ☐ No | |
| Rep Payee Name: | Rep Payee Phone: |

| | |
|---|---|
| Do you have checking accounts? ☐ Yes ☐ No | Do you have savings accounts? ☐ Yes ☐ No |
| Do you own any property? *If yes attach description* | ☐ Yes ☐ No |
| Have you sold/disposed of any assets, including real estate in the last 2 years? | ☐ Yes ☐ No |
| Do you have any other assets not listed above (excluding personal property)? | ☐ Yes ☐ No |

| | |
|---|---|
| Military enlistment length: ____ years From _____ To _____ | Combat: ☐ Yes ☐ No |
| Branch (please circle) WWII Korea Vietnam Grenada Panama Desert Storm OEF OIF Other | |
| Service period (please circle) Army Navy Marine Air Force National Guard Other | |

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*Revised March 2016*

# BEDFORD VA HOUSING APPLICATION

| **How did you hear about Bedford Veterans Quarters:** | |
|---|---|
| Agency Name: | Counselor Name: |
| Contact Number: | Address: |
| Are you currently utilizing the Bedford VA for Services? ☐ Yes ☐ No | |
| If not, are you interested in enrolling for VA healthcare? ☐ Yes ☐ No | |
| Particular Service request: | |

| **Primary Care Physician** | **Case Manager / Social Worker** |
|---|---|
| Name: | Name: |
| Address: | Agency: |
| Phone: | Phone: |
| Email: | Email: |

| **Current Landlord:** | **Previous Landlord:** |
|---|---|
| Name: | Name: |
| Address: | Address: |
| Home Phone: | Home Phone: |
| Length of Stay: | Length of Stay: |

| **Current Employer:** | **Former Employer:** |
|---|---|
| Position: | Position: |
| Supervisor: | Supervisor: |
| Phone: | Phone: |
| Dates Employed: | Dates Employed: |

| **Personal Reference:** | Relationship: | Phone: |
|---|---|---|

| **In case of emergency notify:** | Relationship: |
|---|---|
| Address: | Phone: |

I understand I must pay a security deposit for this room prior to occupancy. I understand that my eligibility for housing will be based on applicable income limits and by management's selection criteria. Under penalty of perjury, I certify that the information presented in this application is true and accurate to the best of my knowledge. The undersigned further understands that providing false statements or information constitutes an act of fraud. False, misleading or incomplete information will lead to cancellation of this application or termination of a lease agreement after occupancy. I agree to comply with income recertification requirements, including the annual submission of information regarding all sources of income from employers and government programs, including income from assets such as bank accounts, CD's, & 401K's.

**SIGNATURE:** _____ **DATE:** _____

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**Name** _____

**Address** _____

**City, State, Zip** _____

## INFORMATION RELEASE WAIVER

EXPLANATION: YOUR SIGNATURE ON THIS INFORMATION RELEASE WAIVER IS NECESSARY FOR THE PROCESSING OF YOUR CERTIFICATION/RECERTIFICATION. YOU SHOULD BE AWARE THAT A CREDIT REPORT WILL BE ORDERED INITIALLY AND MAY BE REPEATED IF NECESSARY. THIS RELEASE AUTHORIZES VERIFICATION OF INFORMATION REGARDING YOU FROM SOURCES SUCH AS, BUT NOT LIMITED TO: BANKING INSTITUTIONS, LANDLORDS, SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF WELFARE, DEPARTMENT OF EMPLOYMENT & TRAINING, YOUR EMPLOYER, ETC.

---

I AUTHORIZE YOU TO RELEASE TO CARITAS COMMUNITIES, INC., MANAGING AGENT, ALL INFORMATION SPECIFICALLY REQUESTED BY SAME FROM YOU TO VERIFY MY INCOME AS WELL AS CREDIT, LANDLORD AND OTHER REFERENCES AS MAY BE NECESSARY. IT IS UNDERSTOOD THAT ALL INFORMATION RELEASED WILL BE KEPT AS CONFIDENTIAL AS POSSIBLE. HOWEVER, YOU SHOULD BE AWARE, THE INFORMATION REPORTED MAY BE REVIEWED BY SOMEONE OTHER THAN A CARITAS COMMUNITIES, INC. STAFF PERSON (I.E. ATTORNEY, AUDITOR, ETC.).

CONDITIONS: I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION MAY BE USED FOR THE PURPOSES STATED ABOVE. THE ORIGINAL OF THIS AUTHORIZATION IS ON FILE WITH THE MANAGEMENT OFFICE AND WILL STAY IN EFFECT FOR A YEAR AND A MONTH FROM THE DATE SIGNED.

AS A CONDITION OF CONTINUED OCCUPANCY I FURTHER UNDERSTAND THAT I WILL BE REQUIRED TO SIGN THIS INFORMATION RELEASE WAIVER EACH YEAR AT RECERTIFICATION TIME.

_____

Signature Date Social Security Number

**NOTE: This general consent may not be used to request a copy of a tax return. If a copy of a tax return is needed, IRS Form 4506, "Request for Copy of Tax Form" must be prepared and signed separately.**

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# BANK ACCOUNT VERIFICATION

**Section 1 –** To Be Filled Out By Applicant

**RESIDENT:** _____

Address: _____

Social Security No: _____

*I authorize you to release to Caritas Communities, Inc., managing agent, all information specifically requested below. It is understood that all information released will be kept as confidential as possible. However, you should be aware, the information reported may be reviewed by someone other than a caritas communities, inc. Staff person (i.e. attorney, auditor, etc.).*

**Signature** _____ **Date** _____

**Section 2 -** To Be Filled Out By Your Bank

To Whom It May Concern:

The person named above has applied to a Caritas Communities housing project. Caritas is a non-profit housing company and it is necessary that they have documentation of asset accounts with your institution.

**BANK:** _____

Address: _____

Checking Acct#_____ **6 Month Avg. Bal** _____ Rate of Int.: _____

Savings Acct# _____ **Current Balance** _____ Rate of Int.: _____

Signature: _____ Date: _____

Position: _____

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# AFFIDAVIT OF NO ASSETS

I, _____, attest that i do not have any assets. Should I obtain any bank accounts, CDs, etc., i will immediately notify management and provide them with documentation.

_____
Signature of Resident/Applicant

_____
Date

Warning: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false statements to any department of the United States Government.

# UNDER $5,000 ASSET CERTIFICATION

For households whose combined net assets are less than $5,000.00
Complete only one form per household; include assets of children

**Applicant/Tenant: _____Unit #: _____**

*Complete 1 or 2:*

1. [ ] I/we do not have any assets at this time (skip to #5)
2. [ ] I/we do have assets as follows:

| | | |
|---|---|---|
| Cash on hand | $_____ | |
| Balance on prepaid debit card | $_____ | Interest/Dividend Income: _____ |
| Avg 6 mo checking acct balance | $_____ | Interest/Dividend Income: _____ |
| Current savings acct balance | $_____ | Interest/Dividend Income: _____ |
| 401k/IRA/CD/Money Market | $_____ | Interest/Dividend Income: _____ |
| Stocks/Bonds/Retirement | $_____ | Interest/Dividend Income: _____ |
| Life Insurance (except Term) | $_____ | Interest/Dividend Income: _____ |
| Safe Deposit Box | $_____ | Interest/Dividend Income: _____ |
| Equity in Real Estate | $_____ | Rental Income: _____ |
| Lump Sum Amounts received | $_____ | *i.e. lottery/inheritance/insurance/lawsuit* |
| Other: | $_____ | Interest/Dividend Income: _____ |
| Other: | $_____ | Interest/Dividend Income: _____ |
| Other: | $_____ | Interest/Dividend Income: _____ |

- *For all assets list the cash value which is the market value minus the cost of converting the asset to cash such as broker fees, settlement costs, outstanding loans, early withdrawal penalties, etc.*
- *List only amounts accessible to the household members. For instance, do not list pension or retirement account balances that cannot be accessed without terminating employment*
- *Do not list necessary personal property such as clothing, furniture, televisions, etc.*
- *Include any personal property held as an investment such as artwork, antique cars, coin collections, gems, etc.*

3. The net household assets above are less than $5,000.0 [ ] YES [ ] NO
4. Total annual income from all assets is: _____
5. In the past 2 years I/we have sold or given away assets (such as cash, real estate, etc.) for less than fair market value: [ ] YES [ ] NO
   If YES list asset disposed: _____ Date of disposal: _____
   Fair market value: _____ Amount received: _____

*Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understand that providing false representation herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of a lease agreement.*

_____ _____
(Signature of Tenant) Date

_____ _____
(Signature of Tenant) Date

_____ _____
(Signature of Tenant) Date

_____ _____
(Signature of Tenant) Date

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# VERIFICATION OF EMPLOYMENT

**TO BE COMPLETED BY EMPLOYER**

Company: _____ Employee: _____

Address: _____ City, State, Zip: _____

Contact Telephone for person completing form: _____

**YOU MUST ALSO ATTACH 2 MONTHS OF YOUR MOST RECENT PAYSTUBS**

*(All questions must be answered, if not applicable, please indicate N/A.)*

**1.** Date of employment_____ Position/Occupation_____

**2.** Date of termination (if applicable) _____

**3.** Current rate of regular pay _____ per _____ (hour, week, month, etc.)

**4.** Current rate of overtime pay _____ per _____ (hour, week, month, etc.)

**5.** Number of hours/week employee normally works _____

**6.** Anticipated average amount of overtime/week_____

**7.** Gross **annual** earnings you anticipate for this employee for the next twelve months $_____ (Gross amount including all tips, bonuses, overtime, commissions).

**8.** Anticipated tips, commissions, bonuses $_____

**9.** Do you anticipate any change in the employee's rate of pay in the near future? **YES _____ NO** _____
If Yes: Revised rate $_____. Effective date for revised rate _____

**10.** Do you anticipate any change in the number of hours the employee works? **YES _____ NO** _____
If yes, explain under question #17 below.

**11.** Does this employee receive vacation with pay? **YES _____ NO** _____

**12.** Does this employee receive sick leave with pay? **YES _____ NO** _____

**13.** Amount deducted for medical coverage: $_____

**14.** Amount deducted for savings plan: $_____

**15.** If the employee's work is seasonal or sporadic, indicate lay-off periods: _____

**16.** Does this employee receive an earned income tax credit? **YES _____ NO** _____

**Signature:**_____**Title:**_____**Date**:_____

# DECLARATION OF SECTION 214 STATUS

**Notice to applicants and tenants:**
**In order to be eligible to receive the housing assistance sought, each applicant for or recipient of housing assistance must be lawfully within the United States. Please read the Declaration statement carefully. Sign and return it to the Housing Authority's Admissions Office. Please feel free to consult with an immigration lawyer or other immigration expert of your choosing.**

I, _____ certify under penalty of perjury,[1] that to the best of my knowledge, I am lawfully within the United States because (please check appropriate box):

- ☐ I am a citizen by birth, a naturalized citizen or national of the United States; or
- ☐ I have eligible immigration status and I am 62 years of age or older. Attach evidencefor proof of age,[2] or
- ☐ I have eligible immigration status as checked below (see explanation on reverse side of form). Attach INS document(s) evidencing eligible immigration status, and signed verification consent form.
  - □ Immigrant status under 1001 (a) (15) or 101 (a) (20) of the INA,[3] or
  - □ Permanent residence under 249 of INA,[4] or
  - □ Refugee, asylum or conditional entry status under 207, 208 or 203 of the INA,[5] or
  - □ Parole status under 212 (d) (f) of the INA,[6] or
  - □ Threat to life or freedom under 243 (h) of the INA,[7] or
  - □ Amnesty under 245 of the INA[8]

_____ _____
Signature of Family Member Date

□ Check box on left if signature is of adult residing in the unit who is responsible for child named on statement above.

PHA: Enter INS/SAVE Primary Verification # _____ Date: _____

(See reverse side for footnotes and instructions)

[1]Warning: 18 U.S.C. 1001 provides, among other things, that whoever knowingly and willfully makes or uses a document or writing containing any false, fictitious, or fraudulent statement or entry, in any manner within the jurisdiction of any department or agency of the United States, shall be fined not more than $10,000 or imprisoned for not more than five years, or both.

***The following footnotes pertain to non-citizens who declare eligible immigration status in one of the following categories:***

[2]Eligible immigration status and 62 years of age or older. For non citizens who are 62 years of age or older or who will be 62 years of age or older and receiving assistance under a Section 214 covered program on June 19, 1995. If you are eligible and elect to select this category, you must include a document providing evidence of proof of age. No further documentation of eligible immigration status is required.

[3]Immigration status under 101(a) 15 or 101(a)(20) of INA. A non citizen lawfully admitted for permanent residence, as defined by 101(a)(20) of the Immigration and Nationality Act (INA) as an immigrant, as defined by 101(a)(15) of the INA (8 U.S.C. 1101(a)(20) and 1101(a)(15), respectively (immigrant status). This category includes a non-citizen admitted under 210 or 210A of the INA (8 U.S.C. 1160 or 1161), (special agricultural worker status), who has been granted lawful temporary resident status.

[4]Permanent residence under 249 of INA. A non citizen who entered the U.S. before January 1, 1972 or such later date as enacted by law, and has continuously maintained residence in the U.S. since then, and who is not ineligible for citizenship, but who is deemed to be lawfully admitted for permanent residence as a result of an exercise of discretion by the Attorney General under 249 of the INA (8 U.S.C. 1259) [amnesty granted under INA 249].

[5]Refugee, asylum, or conditional entry status under 207, 208, or 203 of INA. A non citizen who is lawfully present in the U.S. pursuant to an admission under 207 of the INA (8 U.S.C. 1157) (refugee status), pursuant to the granting of asylum (which has not been terminated under 208 of the INA (8 U.S.C. 1158) [asylum status] or as a result of being granted conditional entry under 203 (a)(7) of the INA (U.S.C. 1153 (a) 7)) before April 1, 1980, because of persecution or fear of persecution on account of race, religion or political opinion or because of being uprooted by catastrophic national calamity [conditional entry status].

[6]Parole status under 212(d)(5) of INA. A non-citizen who is lawfully present in the U.S. as a result of an exercise of discretion by the Attorney General for emergent reasons or reasons deemed strictly in the public interest under 212(d)(5) of the INA (8 U.S.C 1182(d)(5)) [parole status].

[7]Threat to life or freedom under 243(h) of INA. A non citizen who is lawfully present in the U.S. as a result of the Attorney General's withholding deportation under 243(h) of the INA (8 U.S.C. 1253(h)) [threat to life or freedom].

[8]Amnesty under 245A of INA. A non citizen lawfully admitted for temporary or permanent residence under 245A of the INA (5 U.S.C. 1255a) [amnesty granted under INA 245A].

**Instruction to Housing Authority:** Following verification of status claimed by persons declaring eligible immigration status (other than for non-citizens age 62 or older and receiving assistance on June 19, 1995), the PHA must enter INS/AVE Verification Number and date that it was obtained. A PHA signature is not required.

**Instructions to Family Member For Completing Form:** On opposite page print or type first name, middle initial(s) and last name. Place an "X" or "✓" in the appropriate boxes. Sign and date at bottom of page. Place an "X" or "✓" in the box below the signature if the signature is by the adult residing in the unit who is responsible for child.

mbhp
metropolitan boston housing partnership
125 Lincoln Street, 5th Floor, Boston, MA 02111-2503
Phone: (617) 859-0400 | Toll Free: (800) 272-0990 (MA Only)
www.mbhp.org

# DRUG AND / OR VIOLENT CRIMINAL ACTIVITY CONSENT FORM

By signing below, I give my consent to Metropolitan Boston Housing Partnership, Inc. (MBHP), to obtain information from law enforcement agencies (including but not limited to the MA Criminal History Systems Board, police departments, probation departments) relating to any drug related or violent criminal activity.

I understand that if MBHP determines that I as an adult family member have participated in drug related or violent criminal activity the family (and/or live-in-aide) may be denied eligibility, the opportunity to transfer, or be terminated from the MBHP Rental Assistance Program.

Signatures:

| | |
|---|---|
| Head of Household | Date |
| Other Adult Family Member | Date |
| Other Adult Family Member | Date |
| Other Adult Family Member | Date |
| Live-in-aide | Date |

*The above consent expires 27 months after the date signed*.

*<u>To Head of Household:</u> You may be terminated from the MBHP Rental Assistance Program if you or another adult family member and/or live-in-aide is involved with drug related or violent criminal activity.*

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Date: _____

To: Metropolitan Boston Housing Partnership

125 Lincoln St, 5th Floor

Boston, MA 02111

I authorize my information be shared with Bedford Veterans Quarters, 204 Springs Road, Bedford, MA.

Signed: _____

*OMB Number: 2900-0260*
*Estimated Burden: 2 minutes*

# Department of Veterans Affairs

# REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

**Privacy Act and Paperwork Reduction Act Information:** The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

**ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.**

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

ENRM VETERAN HOSPITAL, 200 SPRINGS ROAD, BEDFORD MA 01730

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

CARITAS COMMUNITIES STAFF AT BEDFORD VETERANS QUARTERS (BUILDING 5)

**VETERAN'S REQUEST:** I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

Discussions with VA staff for veteran housing

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

COMMUNICATION BETWEEN VA AND CARITAS COMMUNITIES FOR VETERANS IN BUILDING 5 TO ENSURE COMMUNITY OF CARE AND ONGOING SUPPORT OF NEEDS.

**NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM**

**AUTHORIZATION:** I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

THIS RELEASE OF INFORMATION WITHH TERMINATE WITH VETERAN MOVES OUT OF THE BEDFORD VETERANS QUARTERS.

**I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.**

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

**FOR VA USE ONLY**

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

**TYPE AND EXTENT OF MATERIAL RELEASED**

DATE RELEASED

RELEASED BY

*OMB Number: 2900-0260*
*Estimated Burden: 2 minutes*

# Department of Veterans Affairs

## REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

**Privacy Act and Paperwork Reduction Act Information:** The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

**ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.**

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

ENRM VETERAN HOSPITAL, 200 SPRINGS ROAD, BEDFORD MA 01730

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERABS NORTHEAST OUTREACH CENTER CASE MANAGEMENT STAFF AT BEDFORD VETERANS QUARTERS (BUILDING 5).

**VETERAN'S REQUEST:** I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

DISCUSSION BETWEEN VA STAFF AND VETERANS NORTHEAST OUTREACH CENTER STAFF REGARDING VETERAN'S APPLICATTON FOR HOUSING AT BEDFORD VETERANS QUARTERS

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

COMMUNICATION BETWEEN VA AND THE VETERANS NORTHEAST OUTREACH CENCER STAFF REGARDING VETERAN'S APPLICATION FOR HOUSING AT BEDFORD VETERANS QUARTERS.

**NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM**

**AUTHORIZATION:** I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

THIS RELEASE OF INFORMATION WITHH TERMINATE WITH VETERAN MOVES INTO THE BEDFORD VETERANS QUARTERS.

**I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.**

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

**FOR VA USE ONLY**

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

**TYPE AND EXTENT OF MATERIAL RELEASED**

DATE RELEASED

RELEASED BY