Healthcare Coordination Division

Assistance Request:

Date of Request: _____

Name: _____ **Phone/Email:** _____

County/or Zip code: _____ **Gender:** Female Male **Dependent:** Y N

Branch of Service: _____ **Dates of Service:** _____

Enrolled in VA Healthcare System? Yes No **Service Connected?** Yes No

How did you hear about our program? _____

Details:

_____

_____

_____

Follow-Up Actions:

_____

_____

_____

___ V.A healthcare navigation issues	Community Referral __ Resource to or for:
___ V.A Billing, Eligibility issues	V.S.O Referral YES___ No___
____Elders: Housing__, Medicare__, Medicaid__ home health healthcare__ Referral__ ____Facility Discharge issues	
Suicide/Mental Health issues __	Other:

INTAKE BY: Phone Call: _____ Event: _____ Drop in: _____ Email: _____ Website _____
Initial _____