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South Texas Afghanistan Iraq Veterans Association

**Medical Vouchers**

Operation Vet Care is a program that aims to provide vouchers/stipends to veterans for basic medical needs required to receive a medical diagnosis and treatment. Each voucher provided to veterans will range from $100-$500 for costs associated with mental and Behavioral Health, co-pays, labs, x-ray, doctor’s visits, specialty doctors, etc. We understand that some veterans do have medical insurance, based on disability rating, their financial rated for copays and other medical costs will vary depending on the veteran’s scheduler rating for each diagnosis at the VA. Our mission is to advocate, educated, and assist veterans to any needed resources, funding, medical care, and emotional support.

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**Medical Vouchers**

**Application Checklist**

 DD-214 Member 4

 Copy of government issued ID (VA card, CaC card, DL, ID, Passport)

 Complete STAIVA Form 101 (Registration Form)

 Letter of Plan of Action/ Address Concerns of Diagnosis

 Mental Assessment

 Physical Assessment

 Media Consent and Release Form

 Applicant Understanding

South Texas Afghanistan Iraq Veterans Association

**REGISTRATION FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date: / / | | | | | | | | | | | | | | | | | | | | | | | Registered Voter: ❑ Yes ❑ No | | | | | | | | | | | | | | | | | | | | | | |
| **Veteran INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Veteran’s Last name: | | | | | | | | | | | | First: | | | | | | | Middle: | | | ❑ Mr.  ❑ Mrs. | | | | | ❑ Miss  ❑ Ms. | | | | | | Marital status (circle one) | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | | | | | | | |
| Are you a U.S. Citizen: | | | | | | | E-mail Address: | | | | | | | | | | | Birthplace: | | | | | | | | | | | Birth date: | | | | | | | | | Age: | | Sex: | | | | | |
| ❑ Yes | | | ❑ No | | | |  | | | | | | | | | | |  | | | | | | | | | | | / / | | | | | | | | |  | | ❑ M | | | ❑ F | | |
| Street address: | | | | | | | | | | | | | | | | | | | | Cell phone no.: | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | | | ( ) | | | | | | | | | | | | |
| P.O. Box: | | | | | | | | | City: | | | | | | | | | | | | | | | | State: | | | | | | | | | | | | ZIP Code: | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | |
| Occupation: | | | | | | | | | Employer: | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | | | |
| Ethnicity: | | | | ❑ African American ❑ Anglo American | | | | | | | | | | | | | | | | | | | | ❑ Pacific Islander | | | | | | | | | | | ❑ Middle Eastern American | | | | | | | | |  | |
| ❑ Native American | | | | | ❑ Caucasian | | | | | ❑ Asian American | | | | | | ❑ Mexican American | | | | | | | | ❑ European American | | | | | | | | | | | | ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Race: ❑ Hispanic    ❑White ❑Black ❑Asian | | | | | | | | | | | | | Religion: | | | | Education Level: | | | | | | | | | | | | | | | | | Are you currently homeless? | | | | | | | | | |  | |
|  | |  | | | |  | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | ❑ Yes ❑ No | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Service INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please submit copy of Member 4 DD 214) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Branch of Service: | | | | | | | | Type of Discharge | | | | | | | Start Date:  Release Date: | | | | | | | | | | | | | | | Status: | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | ❑ Active ❑ National Guard ❑ Reserve | | | | | | | | | | | | | | | |
| Are you a disabled veteran? | | | | | | | | ❑ Yes | | | ❑ No | | | | Military Job Tittle(s) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Campaign Badge Information: | | | | | | | | | | | | | | Are you enrolled at a VA clinic: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| ❑ OND ❑ OIF ❑ OEF ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | ❑ Harlingen ❑ McAllen ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IN CASE OF EMERGENCY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative | | | | | | | | | | | | | | Relationship to veteran: | | | | | | | | | | | | phone no.: | | | | | | | | | | | | Work phone no.: | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | | ( ) | | | | | | | | | | | | ( ) | | | | | | |
| Street Address: | | | | | | | | | | | | | | | | | | | | | City: | | | | | | | | | | State: | | | | | | | | Zip Code: | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | |  | | | | | | |
| The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize STAIVA to release any information required to process statically data. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | | | |  | |
|  | *Veteran signature* | | | | | | | | | | | | | | | | | | | | | | | | |  | | *Date* | | | | | | | | | | | | | | | |  | |

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Letter of Plan of action/ Address concerns or diagnosis:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

South Texas Afghanistan Iraq Veterans Association

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**Media Consent and Release Form**

Without expectation of compensation or other remuneration, now or in the future, I hereby give my consent to ***South Texas Afghanistan Iraq Veterans Association (STAIVA),*** its affiliates and agents, to use my image and likeness and/ or any interview statements from me in its publications, advertising or other media activities (including the Internet). This consent includes, but is not limited to:

1. Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/ or record my voice;
2. Permission to use my name; and
3. Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photographs(s), tape(s) or reproduction(s) of me, and/ or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the Internet), in theatrical media and/or in mailings for educational and awareness.
4. I hereby release South Texas Afghanistan Iraq Veterans Association (STAIVA) and its agents from all claims which may arise out of or are in any way connected with such use.

This consent is given in perpetuity and does not require prior approval by me.

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The below signed parent or legal guardian of the above- named minor child hereby consents to and gives permission to the above on behalf of such minor child.

**Signature of Parent**

**or Legal Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Print Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The following is required if the consent form must be read to the parent/legal guardian:*

I certify that I have read this consent form in full to the parent/legal guardian whose signature appears above.

**Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

South Texas

Afghanistan Iraq Veterans Association

HEALTH QUESTIONAIRE

STAIVA

PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete this questionnaire so that we are able to provide you the best possible car. Check any problems below that you have now and/or have had trouble within the past.

\_\_\_\_Chest Pain \_\_\_\_\_ Osteoarthritis

\_\_\_\_ Heart Attack \_\_\_\_\_ Rheumatoid Arthritis

\_\_\_\_ High Blood Pressure \_\_\_\_\_ Hepatitis

\_\_\_\_ Low Blood Pressure \_\_\_\_\_ Blood Clots

\_\_\_\_ Poor circulation \_\_\_\_\_ Diabetes

\_\_\_\_ Difficulty Breathing \_\_\_\_\_ Bleeding/Bruising Easily

\_\_\_\_ Tuberculosis \_\_\_\_\_Hearing Impairment

\_\_\_\_ Respiratory Disease \_\_\_\_\_ Visual Impairment

\_\_\_\_ Numbness to Hands and feet \_\_\_\_\_ Skin Rash/Disease

\_\_\_\_ Head Injury \_\_\_\_\_ Severe Night Pain

\_\_\_\_ Stroke \_\_\_\_\_Cancer

\_\_\_\_ Seizures \_\_\_\_\_ Night Sweats

\_\_\_\_ Difficulty with Balance \_\_\_\_\_ Osteoporosis

\_\_\_\_ Frequent Falls \_\_\_\_\_ Bladder Problems

\_\_\_\_ Blackouts \_\_\_\_\_ Surgery Please list:

\_\_\_\_ Other Orthopedic Injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_\_\_\_\_\_

Do you exercise? \_\_\_\_\_\_\_\_ If so, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women, is there any chance of pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10 rate your problem area when it acts up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List some activities that seem to aggravate your problem area: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List some activities that seem to relieve your problem area: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other special problems/concerns we should know about?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Applicant of Understanding**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am seeking assistance through the **Medical Voucher program** and I have furnished all required documentation provided to me by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, staff of ***South Texas Afghanistan Iraq Veterans Association*** (**STAIVA**).

(Please Initial)

\_\_\_\_1. I understand that I will provide proper documentation to prove my expenses were used for the reason (s) stated above.

\_\_\_\_2. I understand that proof of documents MUST be provided within 30 days from today

\_\_\_\_3. I understand that all information provided to STAIVA is true and valid

\_\_\_\_4. I understand that I will actively seek courses in financial responsibility

\_\_\_\_5. I understand that if I fail to comply with any of the statements above, I will lose any and all future assistance from STAIVA

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

South Texas Afghanistan Iraq Veterans Association