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

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: ❑ Yes ❑ No	E-mail Address:	Birthplace:	Birth date: / /	Age:	Sex: ❑ 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: ❑ OND ❑ OIF ❑ OEF ❑ Other _____		Are you enrolled at a VA clinic: ❑ 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*

South Texas Afghanistan Iraq Veterans Association

Letter of Plan of action/ Address concerns or diagnosis:

_____ _____

Signature Date

South Texas
Afghanistan Iraq Veterans
Association

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:

a) Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/ or record my voice;
b) Permission to use my name; and
c) 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.
d) 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:** _____

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

____ Heart Attack

____ High Blood Pressure

____ Low Blood Pressure

____ Poor circulation

____ Difficulty Breathing

____ Tuberculosis

____ Respiratory Disease

____ Numbness to Hands and feet

____ Head Injury

____ Stroke

____ Seizures

____ Difficulty with Balance

____ Frequent Falls

____ Blackouts

____ Other Orthopedic Injuries

_____ Osteoarthritis

_____ Rheumatoid Arthritis

_____ Hepatitis

_____ Blood Clots

_____ Diabetes

_____ Bleeding/Bruising Easily

_____Hearing Impairment

_____ Visual Impairment

_____ Skin Rash/Disease

_____ Severe Night Pain

_____Cancer

_____ Night Sweats

_____ Osteoporosis

_____ Bladder Problems

_____ Surgery Please list:

_____

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_____