

**CAMDEN COUNTY  
VETERANS REFERRAL APPLICATION**

NAME \_\_\_\_\_ DOB \_\_\_\_\_

SSN \_\_\_\_\_

ARE YOU A VETERAN? YES  NO  BRANCH OF SERVICE \_\_\_\_\_

ARE YOU ELIGIBLE FOR VA BENEFITS? YES  NO

DATES OF SERVICE \_\_\_\_\_

NATURE OF DISCHARGE: HONORABLE  GENERAL  OTHER THAN HONORABLE  OTHER

DO YOU HAVE A CERTIFIED COPY OF YOUR DD FORM 214? YES  NO

WHAT WAS YOUR PRIMARY JOB DESCRIPTION WHILE IN THE SERVICE? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CURRENT OCCUPATION OR EMPLOYER: (NAME, ADDRESS, PHONE NUMBER, SUPERVISOR) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MARITAL STATUS: MARRIED  DIVORCED  SINGLE  RELATIONSHIP

DO YOU HAVE CHILDREN? YES  NO  IF YES, HOW MANY/AGES \_\_\_\_\_

\_\_\_\_\_

HAVE YOU EVER BEEN DIAGNOSED WITH A DISORDER BY VETERANS AFFAIRS? YES  NO

IF YES, EXPLAIN: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_

DATE OF DIAGNOSIS: \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

WHERE HAVE YOU ATTENDED TREATMENT? INCLUDE AGENCY, ADDRESS AND THERAPIST NAME  
(PLEASE LIST ALL INPATIENT AND OUTPATIENT FACILITIES AND/OR HALFWAY HOUSES) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE? YES  NO  IF YES, EXPLAIN:

(PLEASE INCLUDE SUBSTANCE ABUSED, FREQUENCY OF USE, AGE WHEN BEGAN USE, LAST USE): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HAVE YOU EVER BEEN ARRESTED, CHARGED, CONVICTED, CITED OR HELD BY ANY LAW ENFORCEMENT OR JUVENILE AUTHORITITES IN THE UNITED STATES REGARDLESS OF WHETHER THE CHARGE WAS DROPPED OR DISMISSED ON ANY OCCASION, OTHER THAN THIS ARREST? YES  NO  IF YES, EXPLAIN: (INCLUDE NATURE OF ARREST, DATE WHEN ARRESTED, THE JURISDICTION WHERE YOU WERE ARRESTED AND THE DISPOSITION OR OUTCOME OF YOUR CASE:) \_\_\_\_\_

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

ARE YOU CURRENTLY ON BAIL OR ANY OTHER CRIMINAL MATTER IN THIS OR ANY OTHER JURISDICTION? YES  NO  IF YES, EXPLAIN: \_\_\_\_\_

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

BY SIGNING THIS APPLICATION, I AM INDICATING THAT I HAVE READ, OR HAD READ TO ME AND FULLY UNDERSTAND THE VETERANS REFERRAL APPLICATION. I UNDERSTAND AND AGREE THAT I AM VOLUNTARILY ENTERING THIS PROGRAM AND WILL WORK WITH MY LAWYER AND MENTOR TO SUCCESSFULLY COMPLETE THE TREATMENT AND ALL CONDITIONS NECESSARY TO COMPLETE THE PROGRAM SUCCESSFULLY.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

REFERRING AGENCY: _____
CONTACT PERSON: _____
ADDRESS: _____
PHONE: _____ EMAIL: _____

PLEASE RETURN COMPLETED FORM TO LT. ERIC WREN AT  
[VETERANSDIVERSION@CCPROSECUTOR.ORG](mailto:VETERANSDIVERSION@CCPROSECUTOR.ORG)