Work 2 Stay Program

Work 2 Stay program that Operation Veterans' Hope (O.V.H) is offering the opportunity for you as a veteran, the chance to get back on your feet by offering an environment where you will work to earn your stay. Also, this will give you a recent employment experience if needed. You will have the chance to learn computer skills, resume building and other opportunities while staying in the program. Things that you will be responsible for while in the Work 2 Stay program:

- Working in the Thrift Store during operating hours which will be Mondays thru Saturdays from 9AM to 6PM and Sundays and we are closed. You will be scheduled for 40 hours out of the week.
- Helping sort merchandise when it is dropped off at our location.
- Hanging and Pricing items.
- Helping customers when needed.
- Participant in 50% of special events the O.V.H will be attending or hosting.

You are permitted to smoke outside in the smoking area, DO NOT smoke out front right in front of the door. At no time is smoking allowed in the building. If you earn 10 derogatory marks, you will be removed from the program. ½ mark for starting late, ½ mark for taking too long of a break. 5 marks for refusing to work on a scheduled day. ½ mark for leaving the store unmanned. At no time is there any alcohol permitted on the premises, caught having alcohol on the premise will result in immediate removal from the program

If at any time, if you have an issue with any veteran who is in the program, please talk O.V.H director or even a board member and inform them of your situation.

Operation Veterans' Hope

Work 2 Stay Application

Applicant Information

Full Name: _____ Date: _____

Last *First* *M.I.*

Previous Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone: _____ Email _____

Date of Birth: _____ Social Security No.: _____ Place of Birth: _____

Mothers maiden name: _____

Are you a citizen of the United States? YES ☐ NO ☐

Are you authorized to work in the U.S. YES ☐ NO ☐

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain: _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Diploma: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Military Service

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: _____

If other than honorable, explain: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

Signing the application will allow Operation Veterans' Hope (O.V.H) to conduct a background check which is required to be able to receive help from O.V.H. Failure to sign or if anything felonies are reported, you will not be able to participate in the Work 2 Stay program.

We are glad that you are here, we are here to provide an environment where you will be able to get back onto your feet. Remember, this is not a free ride, you will be required to earn your stay.

Please make sure that you have read the information about the Work 2 Stay Program.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	Date of last physical exam:

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					

	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		Grandmother *Maternal*		
	☐ M ☐ F		Grandfather *Maternal*		
	☐ M ☐ F		Grandmother *Paternal*		
	☐ M ☐ F		Grandfather *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	