# 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__<br>____Facility Discharge issues | |
| Suicide/Mental Health issues __ | Other: |

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