OMB Control Number: 2900-XXXX
Estimated Burden: 15 minutes
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DEPARTMENT OF VETERANS AFFAIRS

Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP)

Intake Form

Purpose and Instructions

The SSG Fox SPGP Intake Form must be used by eligible entities that participate in the SSG Fox Suicide Prevention Program for a one-time capture of an eligible individual's demographic, Veteran Status, History of Use of VA services and any anticipated challenges that an eligible individual may experience during participation in the program.

Paperwork Reduction Act and **Privacy Statement:** This information is being collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, we may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended to complete this eligibility screening will average 15 minutes. This includes the time needed to follow instructions, gather the necessary facts, and respond to the questions. Any information provided will be kept private to the extent provided by law. Participation in this survey is voluntary, and failure to respond will not have any impact on a participant's entitlement to benefits.

The form submission deadline for all eligible entities is at or after the first visit with the eligible individual but prior to the next visit. VA intends to review the information from each intake form, which will help VA understand eligible individuals who are participating in the program and what may need to be modified in the program to support those eligible individuals' needs.

The form must be completed and submitted electronically for each eligible individual associated with the eligible grantee. Additional information for using the online Form will be available upon eligible entity award.

This Form contains the following sections:

Section 1: Demographics
Section 2: Eligible Individual Military History and VA Benefits Review
Section 3. Referral and Previous Suicide Prevention Services
Section 4. Baseline Mental Health Screening

Section 1. Demographics

Date of Completion [TEXT BOX]
(e.g., MM/DD/YYYY)

First Name [TEXT BOX] Last Name [TEXT BOX] SSN [TEXT BOX]

Date of Birth [MONTH, DAY, YEAR DROP-DOWN]
(e.g., MM/DD/YYYY)

Address [TEXT BOX]

(Full current residential address, include Zip Code)

Phone Number [TEXT BOX]
(xxx-xxx-xxxx)
Age Range:

- ☐ 18-21
- ☐ 22-25
- ☐ 26-30
- ☐ 31-35
- ☐ 36-40
- ☐ 41-45
- ☐ 46-50
- ☐ 51-55
- ☐ 56-60
- ☐ 61-65
- ☐ 66-70
- ☐ 71-75
- ☐ 76-80
- ☐ 81+

Race (Check all that apply) [CHECK BOX]

- ☐ American Indian or Alaskan native
- ☐ Asian
- ☐ Black/ African American
- ☐ Caucasian/ White
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Pacific Islander
- ☐ Multiple Races
- ☐ Other
- ☐ Prefer not to answer

Are you of Hispanic, Latino, or Spanish origin? [CHECK BOX]

- ☐ No, not of Hispanic, Latino, or Spanish origin
- ☐ Cuban
- ☐ Mexican, Mexican American
- ☐ Puerto Rican
- ☐ Other Hispanic, Latino, or Spanish origin

Please specify: [TEXT BOX]

Sex assigned at Birth [SELECT ONE]

☐ Male ☐ Female

Gender Identity (Check all that apply) [CHECK BOX]

☐ Man ☐ Woman ☐ Non-binary ☐ Another gender not described above [TEXT BOX]

Do you identify as transgender? [SELECT ONE]

☐ Yes ☐ No ☐ Prefer not to answer

Marital Status [SELECT ONE]

☐ Married ☐ Domestic Partner ☐ Divorced ☐ Single, never married ☐ Widow/Widower

Section 2. Eligible Individual Military History and VA Benefits Review

In which branch or branches did you serve? (Please select the parent service for Guard and Reserve personnel) [CHECK BOX]

☐ Army
☐ Navy
☐ Air Force
☐ Marines
☐ Coast Guard
☐ Space Force
☐ Public Health Service
☐ National Oceanic and Atmospheric Administration
☐ Unknown

In what era did you serve? (Check all that apply) [CHECK BOX]

☐ September 2001 or later
☐ August 1990 to August 2001 (includes Persian Gulf War)
☐ May 1975 to July 1990
☐ Vietnam Era (February 1961 to May 1975)
☐ November 1952 to January 1961
☐ Korean War (July 1950 to October 1954)
☐ January 1947 to June 1950
☐ World War II (December 1941 to December 1946))

Were you discharged or released under conditions other than honorable? [Y/N/NOT SURE]

☐ Yes ☐ No ☐ Not Sure

Did you sustain any physical or mental disabling injuries during your military service? [Y/N]

☐ Yes ☐ No

Have you received VA Service -Connection rating? [Y/N/PENDING]

☐ Yes ☐ No ☐ Pending

Do you receive compensation from either a disability rating and/or Pension?

☐ Yes ☐ No ☐ Pending

Are you enrolled in VA Healthcare? [SELECT ONE]

☐ Yes ☐ No ☐ Pending

If eligible, are you interested in using VA Healthcare?

☐ Yes ☐ No ☐ Undecided ☐ Prefer not to answer

When was your last contact with any VA services (e.g., Healthcare, Financial Benefits, Homeless Services, Vet Center, etc.)? [SELECT ONE]

☐ 3 months
☐ 6 months
☐ 9 months
☐ 1 year
☐ More than 1 year
☐ Never

Please indicate which services: [TEXT BOX] or [Drop Down]

Do you have Health Care insurance?

☐ Yes ☐ No

If yes-Type of Health Care Insurance
☐ Insurance through a current or former employer or union (of yours or another family member)
☐ Insurance purchased on the Affordable Care Act Healthcare Exchange (also known as Obamacare)
☐ Medicare, for people 65 and older, or people with certain disabilities
☐ Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability
☐ VA (including those who have ever used or enrolled for VA health care)
☐ TRICARE, TRICARE for Life or other military health care
☐ Other

Section 3. Referral and Previous Suicide Prevention Services

How were you referred to SSG Fox SPGP? [TEXT BOX] or [Drop Down]

Is your referral to SSG Fox SPGP a result of an outreach event?

☐ Yes ☐ No

If Yes, what was the date and location of the outreach event? [TEXT BOX] or [Drop Down]

Do you have any challenges that may prevent your participation in the program? [Y/N]

☐ Yes ☐ No

If yes, please describe: [TEXT BOX]

Have you previously received any of the following suicide prevention services?

Please indicate all that apply:

☐ Referral to Mental Health Care
☐ Education
☐ Emergency Clinical Services
☐ Case Management
☐ Peer support services
☐ VA benefits assistance
☐ Assistance with obtaining and coordinating other benefits provided by the federal government, a state or local government, or an eligible entity (Benefits Coordination)
☐ Assistance with emergent needs relating to health care services, daily living services, personal financial planning and counseling, transportation
☐ Temporary income support services,
☐ Fiduciary and representative payee services,
☐ Legal services
☐ Other: [TEXT BOX]

Section 4. Baseline Mental Health Screening

Please complete the assessments listed below

Assessment	Time to Complete
Socio Economic Status (SES)	5-10 Minutes
Patient Health Questionnaire (PHQ-9)	1-2 Minutes
Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWS)	1-2 Minutes
Generalized Self-Efficacy Scale	1-2 Minutes
Interpersonal Support Evaluation List (ISEL-12)	1-2 Minutes