



Post Traumatic Stress **Residential Rehabilitation**
Program (**PRRP**)

Waco PRRP Application Packet

Everything in this packet must be completed by the Veteran and returned for evaluation, along with a ***copy of the Veteran's DD-214***.
(Please do not leave blanks.)

This application will be put on “**HOLD**” until all information is received.

The “Referral Questionnaire” is separate from this packet, but must be included when this packet is returned to the Waco PRRP.

**Post Traumatic Stress
Residential Rehabilitation Program (116/PRRP)**
4800 Memorial Drive
Waco, TX 76711

Phone: (254) 752-6581, ext. 7269
Toll-Free: 1-800-423-2111, Waco ext. 7269
Fax: (254) 754-9386
E-mail: Rita.Larios@med.va.gov

**Director
National Personnel Records Center
GSA (Military Personnel Records)
9700 PAGE AVE
SAINT LOUIS MO 63132-1547**

Today's Date: _____

Name: (Print): _____

Date of Birth: _____ **Branch of Service:** _____

Date of Entry: _____ **Date of Discharge:** _____

Social Security Number: _____

Service Serial Number: _____

Please forward a copy of all my personnel service records relating to my Military and combat history, to include a copy of my DD 214, to the person and address indicated below.

Do not send medical records.

Thank you for your assistance.

Sincerely,

(sign) _____

**Send records to: Chief, PRRP
CTVHCS (116/PRRP)
Building 90, Room 2B-123
4800 Memorial Drive
Waco, TX 76712**

Post Traumatic Stress Residential
Rehabilitation Program (PRRP)
Treatment Contract

The staff of the PRRP is comprised of individuals who have expressed a desire to work with combat veterans in an intense, sometimes emotionally painful situation. It is usually a desire based on a special interest in war-zone veterans and past, positive experiences with them. The staff is aware of the gift combat veterans have made, and seek to provide treatment opportunities appropriate to that gift.

In this spirit, the staff will waste very little time on issues which interfere with or obscure treatment.

To provide an atmosphere in which healing can begin and which maximizes available resources, the PRRP staff endorses the following treatment guidelines:

1. Veterans need to recognize that simple presence in the program will not result in improvement of PTSD symptoms. Veterans need to be committed to change in their attitudes, perceptions, and ways of coping with emotional problems and life stressors.
2. Honest sharing of experiences, feelings, and ideas, and openness to different opinions are necessary for success in our program.
3. Group members are a valuable resource for each other. Giving and receiving feedback from each other is essential.
4. Scheduled treatment activities and assignments are not optional. Unexcused absence from any scheduled treatment, or non-compliance with assignments, will require intervention by the treatment team.
5. Use of non-prescription drugs or alcohol is incompatible with treatment. Observed urine screens will be given upon admission and after passes. Random urine screens and breathalyzers may be performed during the program. Refusal to give a urine specimen or to be breathalyzed will be treated as an admission of substance use. A positive finding on any of these screens will result in discharge from the program. Moreover, emotional numbing with prescribed medications is discouraged, and staff will monitor closely use of and requests for extra medication.
6. Honesty, sharing, and growth can only occur in a safe environment. Consequently, possession of weapons, physical violence, verbal abuse, and threats of violence against staff or another veteran will result in discharge from the program.
7. Wearing of combat fatigues and other military-related clothing is prohibited.
8. No passes will be given for the first 14 days of the program. Subsequent passes are at the discretion of the treatment team and are of a therapeutic design. Weekend passes must be requested by the Wednesday preceding the pass weekend, and must be approved by the treatment team. Sign-outs and sign-ins must be completed for each pass.
9. Individuals accepted into this program are required to abide by all Veterans Affairs policies and regulations governing behavior and conduct in addition to unit policies.

I have read the Program Description, Treatment Contract, and agree to abide by the guidelines set forth.

Veteran's Signature

Date

**Central Texas Veterans Health Care System
Post Traumatic Stress Residential Rehabilitation Program**

DIRECTIONS: Please **complete** the following questionnaire, giving **all the information requested**.
If any part of this questionnaire is left blank, we can not process this application.
If you have any questions regarding this questionnaire, call toll-free (in Texas) 1-800-423-2111, Waco extension 7269.

Date: _____

A. Biographics

Name: _____

Race: _____

Social Security #: _____

Religion: _____

Date of Birth: _____

Age: _____

Present Address: _____

City, ST ZIP: _____

How long have you lived here? _____

Present Telephone Number: (____) _____

Name, address and phone number of someone who will always know where you are:

B. Social History:

1. Current marital status: _____ How many times? _____ Children: _____

C. Psychological Treatment:

1. Are you currently in therapy? No ___ Yes ___ Where? _____

With whom? _____ For how long? _____

Have you been treated for a mental health problem other than PTSD? If yes, please list.

2. How long have you been alcohol/drug free? _____

D. Employment History:

1. Current employment status:

a. Full time _____ Part time _____ Self employed _____

Place of employment: _____

Description of work: _____

Length of time employed: _____

b. Unemployed: Last worked: _____

Do you have a service connected disability? No ___ Yes ___

If yes, what is it for? _____ What percentage? _____ %

E. Legal Problems:

1. Are you currently: on probation _____ awaiting a court appearance _____
on parole _____ awaiting sentencing _____
on bond _____ facing charges _____

F. Military History:

1. Years of service: _____ Overseas: _____

2. Is your trauma non-combat? No ___ Yes ___ **Please describe:** _____

3. Is your trauma combat-related? No ___ Yes ___

Please list your trauma(s): (e.g., death of a buddy, unit ambushed, perimeter overrun, etc.)

1. _____

2. _____

3. _____

Combat time

Combat unit

MOS

Month/Year

4. If you were injured in combat, please describe: _____
