**Application for Center Club**

31 Bowker Street, Boston, MA 02114

(Main) 617-788-1000 / (Fax) 617-788-1080

**Purpose**: Center Club is a rehabilitation program for men and women with a psychiatric disability.

**Eligibility**: Any person 18 years old or older with a mental health diagnosis who lives in the DMH Metro Boston Area (City of Boston, Brookline, Cambridge, Chelsea, Revere, Somerville, Winthrop) is eligible for Center Club.

**How to Request membership in Center Club**: This application form should be filled out by the applicant’s mental health provider (for example, DMH case manager, therapist, psychiatrist, residential program director, ACCS Worker). The Application should be signed by the referring person and the applicant. The attached Authorization for Release of Information should be signed by the applicant. These forms should be sent to the Center Club Intake Coordinator (US Mail, fax or email).

**Application Date**

**Last Name First Name**

**Street**

**City** **State** **Zip**

**Home Phone** (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell Phone (\_\_\_\_\_\_)**

**Email Address Date of Birth**

**Gender** (please circle):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Marital Status** (please circle): S M W D Sep

**Number of Children** (under 18): Are they living with you?

If your children do not live with you, do you have scheduled visitations with them? Yes No

**Language Preference**:

**Income Source** (please circle): Employment (FT, PT), SSI, SSDI, Trans. Assist., VA, Savings, Family, Other

**Are you a veteran? Yes No**

**Are you a registered voter? Yes No**

**Education** (please circle highest level): 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, GED, Some College, Associates Degree, Bachelor’s Degree, Some Graduate School, Graduate Degree (indicate degree)

**Are you in school now?** Yes No

If yes, what school?

Created 1/5/1985

Reviewed Annually

Revised 02/07/2019

**Employment Status:** *(Check Only One Of The Options Below):*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **√** | **Description** | **√** | **Description** | **√** | **Description** |
| [ ]  | Active Military Duty | [ ]  | Supported Employment | [ ]  | Unemployed Now*(History of Employment)* |
| [ ]  | Full Time *(35 hours or More)* | [ ]  | Transitional Employment | [ ]  | Never Employed |
| [ ]  | Part Time *(Less than 35 hours)* | [ ]  | Volunteer Only | [ ]  | Not in Labor Force |
| [ ]  | Self Employed | [ ]  | Retired | [ ]  | Unknown |

**Living Arrangement:** Living Arrangement is defined as the person’s primary place of residence *(Check Only One of the Options Below):*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **√** | **Description** | **√** | **Description** | **√** | **Description** |
| [ ]  | Lives Alone, no minor dependents | [ ]  | Inpatient Facility | [ ]  | Rest Home |
| [ ]  | Assisted Living | [ ]  | Lives with minor dependents | [ ]  | Homeless Shelter |
| [ ]  | Foster Home | [ ]  | Lives with adult non-relatives | [ ]  | Lives on the Street |
| [ ]  | Group Living Environment | [ ]  | Nursing home, non-rehab | [ ]  | Temporary Living |
| [ ]  | DMH Shelter**\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ShShelter\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | Lives with Adult Relatives | [ ]  | Unknown |

**Ethnicity:** Ethnicity is defined as the group of people who you are connected to by a common national origin, history, language or customs and cultural experiences. *(Please check only one of the options below):*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **√** | **Description** | **√** | **Description** | **√** | **Description** | **√** | **Description** |
| [ ]  | Albanian | [ ]  | Eritrean | [ ]  | Israeli | [ ]  | Portuguese |
| [ ]  | American | [ ]  | Ethiopian | [ ]  | Italian | [ ]  | Puerto Rican |
| [ ]  | Armenian | [ ]  | Filipino | [ ]  | Japanese | [ ]  | Russian |
| [ ]  | Bosnian | [ ]  | French | [ ]  | Korean | [ ]  | Salvadoran |
| [ ]  | Brazilian | [ ]  | German | [ ]  | Laotian | [ ]  | Somali |
| [ ]  | Cambodian | [ ]  | Greek | [ ]  | Lebanese | [ ]  | Thai |
| [ ]  | Canadian | [ ]  | Guatemalan | [ ]  | Mexican | [ ]  | Tibetan |
| [ ]  | Cape Verdean | [ ]  | Haitian | [ ]  | Moroccan | [ ]  | Ukrainian |
| [ ]  | Chinese | [ ]  | Hmong | [ ]  | Nicaraguan | [ ]  | Venezuelan |
| [ ]  | Colombian | [ ]  | Honduran | [ ]  | Nigerian | [ ]  | Vietnamese |
| [ ]  | Congolese | [ ]  | Indian | [ ]  | Pakistani | [ ]  | West Indian / Caribbean |
| [ ]  | Costa Rican | [ ]  | Iranian | [ ]  | Panamanian | [ ]  | Two or More |
| [ ]  | Dominican | [ ]  | Iraqi | [ ]  | Peruvian | [ ]  | Chooses to Not Identify |
| [ ]  | Egyptian | [ ]  | Irish | [ ]  | Polish | [ ]  | Other |

**Race:** The following designations come from the federal government *(Please check only one of the options below):*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **√** | **Description** | **√** | **Description** | **√** | **Description** |
| [ ]  | American Indian/Alaska Native | [ ]  | Black/Hispanic | [ ]  | White/Non-HispanicTwo or More |
| [ ]  | Asian | [ ]  | Pacific Islander/Hawaiian | [ ]  | Two or More |
| [ ]  | Black or African American | [ ]  | White/Hispanic | [ ]  | Chooses to Not Identify |

**Are you a DMH client? Yes No**

**If you are, please check the DMH site where you get services:**

|  |  |
| --- | --- |
| **√** | **DMH Site** |
| [ ]  | Lindemann/Cambridge-Somerville Site (BLS) |
| [ ]  | Massachusetts Mental Health Center Site (BMS) |
| [ ]  | Fuller/Bay Cove Site (BFS) |

**Social Security # Mass Health Policy #**

**Referred by** Telephone

**Title**

**Agency**

**Address**

**Reasons for Referral to Center Club:**

|  |  |
| --- | --- |
| **√** | **Reasons for Referral to Center Club** |
| [ ]  | Education |
| [ ]  | Employment |
| [ ]  | Health and Wellness |
| [ ]  | Housing |
| [ ]  | Peer Support |
| [ ]  | Socialization |
| [ ]  | Life Skills (specify) |
| [ ]  | Access other community services |

**Summary of my reasons for going to Center Club:** Please summarize in your own words and in order of priority, the reasons you would like to come to Center Club.

|  |
| --- |
| **1.** |
| **2.** |
| **3.** |
| **4.** |

**Mental Health Providers:**

Name/Title Telephone

Agency/Address

Name/Title Telephone

Agency/Address

**ACCS Provider**

Name/Title Telephone

Agency/Address

**Other Service Providers** (e.g., MRC, Housing, Probation, PACT, Peer Operated Services):

Name/Title Telephone

Agency/Address

Name/Title Telephone

Agency/Address

|  |  |
| --- | --- |
| **Date of Diagnosis:** | **Clinician (please print and sign):** |
| **Axis I** |  |
|  |  |
| **Axis II** |  |
|  |  |
| **Axis III** |  |
|  |  |
| **Axis IV** |  |
|  |  |
| **Axis V** |  |
|  |  |

**Medication (psychiatric)**

(Attach extra sheet if more space is necessary)

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Dose** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Most Recent Psychiatric Hospitalization (if any):**

Place Date

**Medical (non-psychiatric):**

**Non-psychiatric Medical Problems**

**Medication (non-psychiatric)**

(Attach extra sheet if more space is necessary)

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Dose** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Primary Care Physician** Telephone

**Address**

**Name of Emergency Contact or Legally Authorized Representation (LAR):**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone

**Risk Assessment**

This page should be filled out by the referring person together with the applicant.

Applicant’s Name

Assessment completed by

**Situations of Risk (please check all that apply):**

Center Club is rehabilitation program. We strive to promote peer support and independence. This is the reason why Center Club is not a staff intensive program. We want to be a welcoming program for all adults experiencing a psychiatric disability. We believe that a person should have the chance to move on towards rehabilitation even if they have had very difficult experiences in the past. At the same time it is important that the whole clubhouse community feel safe at the club. We depend on each member being able to interact with others in a way that fosters a feeling of safety for all.

**Please do not leave this page blank.**

**1. No situations of risk** **[ ]**

**2. Situations of risk:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **√** | **Situations of Risk** | **Description** | **Past Problem (date)** | **Problem within past two years** |
|  | Aggressive/Assaultive Behavior |  |  |  |
|  | Homicidal Behavior |  |  |  |
|  | Problematic Sexual Behavior |  |  |  |
|  | Involvement with the Criminal Justice System |  |  |  |

**If the applicant has had a past or a current problem with any of the behaviors listed above, or if the applicant has a current or past involvement with the criminal justice system, *please attach a written account of the problematic behaviors or involvement with the criminal justice system (include contact information for probation or parole officers).***

Center Club is a rehabilitation program and not a clinical program. And yet occasions arise when it is helpful for us to know some things about a person’s experiences that may put them at risk.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **√** | **Other Situations of Risk** | **Description** | **Past Problem (date)** | **Problem within past two years** |
|  | Auditory/Visual Hallucinations |  |  |  |
|  | Suicidal Ideation/Attempt |  |  |  |
|  | Substance Abuse (specify) |  |  |  |

**Comments:**

*Please fill out the Authorization for Release or Request of Information on the next page.*

Applicant’s Signature

Referring Counselor’s Signature

#### Center Club

# a program of

#### Bay Cove Human Services

**AUTHORIZATION FOR RELEASE OR REQUEST OF INFORMATION BETWEEN CENTER CLUB STAFF MEMBERS AND MEMBERS OF THE REHABILITATION/TREATMENT TEAM**

I authorize Center Club to obtain information from, forward my confidential records or hold general discussions about my rehabilitation/treatment with members of my treatment/rehabilitation team.

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ This consent is valid for one year from this date

# Rehabilitation/Treatment Team Members (for example, therapist, psychiatrist, residential program director, ACCS worker)

#

|  |  |
| --- | --- |
| Name and Title | Agency |
|  |  |
|  |  |
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### Member/Guardian Signature Date Please Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Florence Mugenyi, Intake Coordinator

Signature of Person Date Please Print Name and Title

### Obtaining Authorization