

FOUNTAIN HOUSE BRONX

Para ayuda con este formulario en español, llama al número (718) 742-9884

To Whom It May Concern:

To be considered for membership, the following must be submitted:

1. A Fountain House Bronx Membership Application and supplementary substance abuse questionnaire (included at the end of application)
2. A detailed psychosocial summary, current or updated within last 90 days
3. A detailed psychiatric assessment, current or updated within last 90 days, signed off by an MD and/or Nurse Practitioner
4. Copies of all Health Insurance cards

It is helpful when all four of these components are submitted together.

Please note that we do not accept referrals for housing.

Home and Community Based Services (HCBS)

When referring for Home and Community Based Services (HCBS) at Fountain House Bronx please mail level of Service Determination, Eligibility Summary, along with a Plan of Care (POC) to Nicole Pickett, MEd, Director of Managed Care Relations via fax, (212) 582-9869 or to the Fountain House Bronx address above, Attn: Nicole Pickett. If you have questions about HCBS at Fountain House Bronx, please call (212) 582-3155.

If you have a question or need assistance in any way, please contact the Membership Office at (718) 742-9884, Ext. 18.

Application information can be sent via fax to (718) 742-9867, emailed to intake@fountainhousebx.org or by mail to:

Fountain House Bronx
Attn: Membership Office
564 Walton Avenue
Bronx, NY 10451

Thank You,
The Membership Team

Rev: 6/2018

MEMBERSHIP APPLICATION

Fountain House Bronx is dedicated to the recovery of people living with mental illness by providing opportunities for our members to live, work, and learn, while contributing their talents through a community of mutual support.

A working community is at the heart of our model. By working together, members regain confidence, make friends, learn new skills, and make progress towards achieving their employment and educational goals. This opportunity to be a part of a successful working community is restorative and builds dignity and self-esteem.

To be eligible for membership an applicant must:

- Be interested in attending Fountain House Bronx, as membership is voluntary.
- Have a primary presenting problem associated with severe and persistent mental illness.
- Be able to get to Fountain House Bronx.
- Not pose a threat to our community
- Be at least 18 years of age.

Fountain House does not discriminate on the basis of race, color, religion, sex, age, national origin, veteran status, sexual orientation, gender identity, disability, or any other basis of discrimination prohibited by law.

“The Clubhouse has control over its acceptance of new members”
Standard #2, International Standards for Clubhouse Programs, ICCD

Prospective Member Information

First Name: _____ MI: _____ Last Name: _____

Date of Birth: ____ / ____ / ____ Age: _____ Gender: _____

Social Security Number: _____ - _____ - _____

Address

Street: _____ Apartment: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ - _____ County: _____

If you live in a housing program, what is the agency of that Program?

Who is recommending you?

Name: _____ Agency Name: _____

Phone (_____) _____ - _____ Type of Agency: _____

Email Address: _____

How long has this person known you? _____ years _____ months

Check if you've had a tour of Fountain House Bronx Date of tour: ____ / ____ / ____

What is your main goal in joining Fountain House Bronx?

- Community Socialize/Friends Education Employment Wellness
 Benefits/Resources Other

Why would Fountain House Bronx be a good place for you?

What challenges or barriers are keeping you from achieving your goals?

Housing Information

Current Housing Type (choose one):

<input type="checkbox"/> Own Home/ Apartment (Non-subsidized)	<input type="checkbox"/> Supportive Apartment
<input type="checkbox"/> Home of Family Member	<input type="checkbox"/> Nursing Home
<input type="checkbox"/> SRO	<input type="checkbox"/> Shelter
<input type="checkbox"/> Supported Apt. (Subsidized)	<input type="checkbox"/> Homeless/ Undomiciled
<input type="checkbox"/> 24 Hr. Supervised Housing	

Do you live alone... YES NO

If NO, with whom do you live? _____

Do you have a history of homelessness? YES NO

If YES, please explain: _____

Do minor children reside in your home? YES NO

If YES, is there or has there ever been any ACS (Administration for Children's Services) involvement? YES NO

Income

(please check-off all that apply & enter monthly amounts)

<input type="checkbox"/> SSI: \$	<input type="checkbox"/> Retirement Benefits: \$
<input type="checkbox"/> SSDI: \$	<input type="checkbox"/> Veteran's Benefits: \$
<input type="checkbox"/> Wages: \$	<input type="checkbox"/> Public Assistance: \$
<input type="checkbox"/> Family/Family Support: \$	<input type="checkbox"/> Other: \$
<input type="checkbox"/> SNAP: \$	Total Income: \$

Ethnicity

(please check all that apply)

<input type="checkbox"/> Black (African American)	<input type="checkbox"/> Black (Afro-Caribbean)
<input type="checkbox"/> Black (African Continent)	<input type="checkbox"/> Black (Other Black)
<input type="checkbox"/> Hispanic (Cuban)	<input type="checkbox"/> Hispanic (Mexican)
<input type="checkbox"/> Hispanic (Puerto Rican)	<input type="checkbox"/> Hispanic (Dominican)
<input type="checkbox"/> Hispanic (South American)	<input type="checkbox"/> Hispanic (Central American)
<input type="checkbox"/> Pacific Islander / Native Hawaiian	<input type="checkbox"/> Native American / American Indian
<input type="checkbox"/> Asian (Far East)	<input type="checkbox"/> Asian (South East)
<input type="checkbox"/> Asian (Indian subcontinent)	<input type="checkbox"/> White (North African)
<input type="checkbox"/> White (Middle Eastern)	<input type="checkbox"/> White (American)
<input type="checkbox"/> White (European)	<input type="checkbox"/> White (Other)

Primary Language: If other than English: _____

Marital Status:

Married Permanent Partner Separated Divorced Widowed
 Single Never Married

Children: Do you have any children? YES NO If YES, how many? _____

Veteran Status: Are you a veteran? YES NO

Citizenship: Are you a US Citizen/Permanent Resident? YES NO

Education

(check all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> Some High School	<input type="checkbox"/> GED
<input type="checkbox"/> High School Diploma	<input type="checkbox"/> Trade School	<input type="checkbox"/> Some College
<input type="checkbox"/> Associate's Degree	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Some Graduate Work
<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Advanced Graduate Degree	

Employment History

Are you currently employed? YES NO

Have you ever worked for pay? YES NO

Have you worked in the last 12 months? YES NO

Please list the number of years you've had paid work: _____

Medical and Psychiatric

Medical Alerts (check all that apply)

<input type="checkbox"/> Chronic Physical Illness	<input type="checkbox"/> Severe Allergic Reactions
<input type="checkbox"/> Asthma	<input type="checkbox"/> New Psychiatric Medication
<input type="checkbox"/> Blind/Visual Impairment	<input type="checkbox"/> Deaf/Hearing Impairment
<input type="checkbox"/> Recent Surgery	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Epilepsy/Seizure Disorder	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Other:	

Alert Memo: _____

Medical & Psychiatric Contacts

Psychiatrist: _____

Agency: _____ Phone: (_____) _____ - _____

Address: _____

How long have you been seeing this psychiatrist? _____ years _____ months

Email Address: _____

Therapist: _____

Agency: _____ Phone: (_____) _____ - _____

Address: _____

How long have you been seeing this therapist? _____ years _____ months

Email Address: _____

Primary care MD: _____

Agency: _____ Phone: (_____) _____ - _____

Address: _____

How long have you been seeing this medical doctor? _____ years _____ months

Email Address: _____

Emergency Contacts

Primary: _____

Phone: (_____) _____ - _____ Relationship: _____

Secondary: _____

Phone: (_____) _____ - _____ Relationship: _____

Medical Insurance

(indicate applicable insurance and provide the policy number)

<input type="checkbox"/> Straight Medicaid:	<input type="checkbox"/> Private
<input type="checkbox"/> Insurance:	<input type="checkbox"/> Medicare:
<input type="checkbox"/> Veteran's Benefits:	<input type="checkbox"/> Family pays:
<input type="checkbox"/> Worker's Compensation:	<input type="checkbox"/> Self pay:
<input type="checkbox"/> Other:	
Medicaid Managed Care (please include name of company):	
Health and Recovery Plan (HARP)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Home and Community Based Services (HCBS)?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Date of Last Physical Exam: _____

Date of Last Dental Exam: _____

Psychiatric Diagnosis (DSM V):

Schizophrenia Schizoaffective Major Depressive Disorder Bipolar

Other: _____

Secondary Diagnosis: _____

Tertiary Diagnosis: _____

Psychiatric Hospitalizations

Total Number of Psychiatric Inpatient Hospitalizations: _____

Please list your first and most recent hospitalization, Indicating name of hospital & dates:

Hospital name	Dates (approximate)
First:	
Most Recent:	

Substance Use History

Do you currently smoke tobacco or use tobacco products?

YES NO

Do you have a history of smoking or using tobacco products?

YES NO

Do you have a history or alcohol or drug abuse? Please answer all questions. Your answers will not influence your application decision

Alcohol YES NO

Drugs YES NO

Have you ever been in treatment for an alcohol or drug problem?

YES NO

If YES, when and where? _____

Are you currently in a treatment or support group for alcohol or drug abuse?

YES NO

If YES, when and where? _____

Are you interested in being in treatment or a support group for alcohol or drug abuse?

YES NO

Legal History

Please answer all questions

Have you ever been in jail?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been in prison?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been convicted of a misdemeanor?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been convicted of a felony?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever physically injured another person?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have any history of violent behavior?	<input type="checkbox"/> YES <input type="checkbox"/> NO

If any of the above questions were answered "YES", please indicate dates, behaviors, precipitants, legal actions, etc:

Questionnaires

The following are two surveys and a questionnaire. They are required by one of our funding sources. Please note that your answers to these questions do not affect your acceptance to Fountain House Bronx.

PLEASE answer the following questions (your answers will not impact any decisions regarding your application):

I get important needs of mine met by my current community	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat	<input type="checkbox"/> Mostly	<input type="checkbox"/> Completely
It is important for me to feel a part of a community.	<input type="checkbox"/> Not at all	<input type="checkbox"/> Somewhat	<input type="checkbox"/> Mostly	<input type="checkbox"/> Completely
How often do you feel that you lack companionship	<input type="checkbox"/> Hardly Ever	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Mostly	<input type="checkbox"/> Completely
How often do you feel left out?	<input type="checkbox"/> Hardly Ever	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Mostly	<input type="checkbox"/> Completely
How often do you feel isolated from others?	<input type="checkbox"/> Hardly Ever	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Mostly	<input type="checkbox"/> Completely

Taking everything into consideration, during the past week how satisfied have you been with your...	<i>Very Poor</i>	<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>
...physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...mood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...household activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...social relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...family relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...leisure time activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...ability to function in daily life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...economic status?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...living/housing situation? *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...ability to get around physically without feeling dizzy or unsteady or falling? *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...your vision in terms of ability to do work or hobbies? *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...overall sense of well-being?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...medication? (If not taking any, check here <input type="checkbox"/> and leave item blank.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...How would you rate your overall life satisfaction and contentment during the past week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Short Form (Q-LES-Q-SF)

Please answer in the context of thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:

- 1) Have you ever felt that you ought to cut down on your drinking or drug use?
 YES NO
- 2) Have people annoyed you by criticizing your drinking or drug use?
 YES NO
- 3) Have you ever felt bad or guilty about your drinking or drug use?
 YES NO
- 4) Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?
 YES NO

CAGE-AID Questionnaire

Signatures

It is very important that all components of this application are absolutely complete. Any missing or incomplete components will, unfortunately, delay the application process. In addition, it is helpful to include all documents at the same time.

Please allow the Membership Team approximately two weeks to review applications. Please contact the Membership Office at **(718) 742-9884, Ext. 18** if **you have any questions.**

Thank you for applying to Fountain House Bronx.

Did you remember to include the following?

- 1) A detailed psychosocial summary, current or updated within last 90 days
- 2) A detailed psychiatric assessment, current or updated within last 90 days, signed off by an MD and/or Nurse Practitioner
- 3) Copies of all Health Insurance cards
- 4) The supplementary substance abuse questionnaire and survey (included on the following page of this application)

_____ Date: _____
Prospective Member Signature

_____ Date: _____
Referral Source Signature