Fountain House Membership Application

The Fountain House vision is that people with mental illness everywhere achieve their potential and are respected as co-workers, neighbors and friends.

Fountain House - a working community - offers people living with mental illness a sense of belonging and the opportunity to form relationships, so they can take the vital steps toward mental health. At Fountain House, members & staff work together in the running of the program. Members volunteer their time in various units and, together with staff, ensure that the organization is operating smoothly and efficiently. It is by working side by side that relationships between and among members and staff are developed. Through these relationships and the meaningful participation in Fountain House work, members build skills, develop a sense of purpose, and strive towards achieving their individual goals.

To be eligible for membership an applicant must:

1. be interested in attending Fountain House, as membership is voluntary.
2. have a primary presenting problem associated with severe and persistent mental illness.
3. be able to get to Fountain House.
4. not pose a threat to our community
5. be at least 16 years of age.

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

First: ___________________ MI: _______ Last: ______________________

DOB: _______________ SSN: _____-____-_______ Gender: ______________________

Place of Birth: ________________________________

**Address**

Street: ___________________________________________ Apt: __________

City: ___________________________________ State: _______________ Zip: __________

Phone: ___________________________________ County: _______________

How long have you resided here? ____________________________________________

Email Address: ____________________________________________

**Who is recommending you?**

Name: ___________________________ Agency: ______________________

Phone: ___________________________ Type of Agency: ______________________

How long have you known this person? __________________________________________

Email Address: ____________________________________________

**Why would Fountain House be a good place for you?:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please check here if you have had a tour of Fountain House.

Date of tour: ___/___/___

**Current Housing Type** (circle one)

1). Own Home/ Apartment (Non-subsidized) 8). Supervised Housing (Part-time Supervision)
2). Home of Family Member 9). Foster Care
3). Rooming/ Boarding House, Hotel 10). Psychiatric Hospital
4). SRO (Temporary) 11). Nursing Home
6). 24 Hr. Supervised Housing 13). Shelter
7). Supportive Apartment 14) Homeless/ Undomiciled

Do you live alone or with others? ______________ if so, with whom? __________________________

Do you have a history of homelessness? ________ If so, please explain: __________________________

______________________________________________________________________________

______________________________________________________________________________

Do minor children reside in your home? __________

If so, is there or has there ever been any ACS (Administration for Children’s Services) involvement? ________

**Income** (circle all that apply & enter monthly amounts)

SSI: $__________ Family/Family Support: $____ Veteran’s Benefits: $___________

SSDI: $__________ SNAP: $______________ Public Assistance: $________

Wages: $__________ Retirement Benefits: $____ Other: __________________________

Total Income: $_______________
**Ethnicity** (circle all that apply)

- African-American
- American Indian/Native American
- Caucasian
- Asian/Chinese/Japanese/Korean
- Middle Eastern
- Pacific Islander
- Latino/Hispanic/Cuban/Mexican/Puerto Rican
- Caribbean/Haitian/Jamaican
- Other: _______________________________________________________________________

**Primary Language**  If other than English, __________________________________________

**Marital Status** (circle one)

- Married
- Permanent Partner
- Widowed
- Single, Never Married
- Separated
- Divorced

**Veteran Status**  Are you a veteran? YES NO

**Education Level** (circle all that apply)

<table>
<thead>
<tr>
<th>Level</th>
<th>Option</th>
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<tr>
<td>Less than High School</td>
<td>Some High School</td>
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<tr>
<td>Trade School</td>
<td>Some College</td>
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<tr>
<td>Some Graduate Work</td>
<td>Master's Degree</td>
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<td>GED</td>
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<td>Associate's Degree</td>
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<td>Bachelor's Degree</td>
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<td>High School Diploma</td>
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<td></td>
<td>Advanced Graduate Degree</td>
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<tr>
<th>School Attended</th>
<th>Years</th>
<th>Major</th>
<th>Did you Graduate?</th>
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**Employment History**

- Have you ever worked for pay? YES NO
- Have you worked in the last 12 months? YES NO

Estimated TOTAL YEARS you have worked for pay: __________________

Estimated TOTAL NUMBER OF JOBS worked for pay: __________________

**Please List All Employment. Be sure to include the most recent and longest job:**

<table>
<thead>
<tr>
<th>Dates</th>
<th>Employer</th>
<th>Title/ Type of work</th>
<th>Hourly Wage &amp; Hours per week.</th>
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Notes: ________________________________________________________________________
Medical Alerts (circle all that apply)
Chronic Physical Illness
Severe Allergic Reactions
Deaf/Hearing Impairment
Asthma
New Psychiatric Medication
Blind/Visual Impairment
Recent Surgery
Diabetes
Epilepsy/Seizure Disorder
Hypertension
Other:__________________________________________________________________________________

Alert Memo:________________________________________________________________________________________

Medical & Psychiatric Contacts
Psychiatrist: ____________________________
Agency:_____________________________________
Phone:_____________________________________
Address:_____________________________________
How long have you been seeing this psychiatrist?__________________________________________________________
Email Address:______________________________________________________________________________________

Therapist: ____________________________
Agency:_____________________________________
Phone:_____________________________________
Address:_____________________________________
How long have you been seeing this therapist?_______________________________________________________________
Email Address:______________________________________________________________________________________

Primary Care MD: ____________________________
Agency:_____________________________________
Phone:_____________________________________
Address:_____________________________________
Email Address:______________________________________________________________________________________

Emergency Contacts
Primary:_____________________________________
Phone:_____________________________________
Relationship:_____________________________________
Secondary:_____________________________________
Phone:_____________________________________
Relationship:_____________________________________

Medical Insurance (indicate applicable insurance and provide the policy number)
Straight Medicaid:__________________________
Private Insurance:__________________________
Medicare:__________________________
Veteran's Benefits:__________________________
Family pays:__________________________
Worker's Compensation:__________________________
Self pay:__________________________
Other:__________________________
Medicaid Managed Care (please include name of company):____________________________________________________

Medicaid Managed Care:____________________________________________________

Date of Last Physical Exam:__________________________
Date of Last Dental Exam:__________________________
**Medications** (please list all medications with respective dosage & frequency)

__________________________________________________________________________________________

**Psychiatric Hospitalizations** Total # of Hospitalizations:_____

Please list all hospitalizations beginning with the first. Be sure to indicate the most recent.
Indicate name of hospital & dates:

1). 6).
2). 7).
3). 8).
4). 9).
5). 10).

Please indicate precipitants to these hospitalizations: _______________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

**Substance Abuse History**

Do you have a history of alcohol or drug abuse?
If an alcohol or substance abuse history exists, please elaborate:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

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<tr>
<th>Name of Substance</th>
<th>Date Started</th>
<th>Last Use</th>
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Have you ever been in treatment for an alcohol or drug problem? YES NO
If so, when and where?____________________________________________

Are you currently in treatment or in a support group for alcohol or drug abuse? YES NO
If so, 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

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<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
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<td>Have you ever been in jail?</td>
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<td>Have you ever been in prison?</td>
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<td>Have you ever been convicted of a misdemeanor?</td>
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<td>Have you had any arrests for felonies?</td>
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<td>Have you ever physically injured another person?</td>
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<td>Do you have any history of violent behavior?</td>
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If any of the above questions were answered "YES", indicate dates, behaviors, precipitants, legal actions, etc.

__________________________________________________________________________________________

_______________________________________________________________________________________

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_______________________________________________________________________________________

Are you currently involved in any programs, work, school, etc. or is there anything else you would like us to know about you?:

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

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 three pieces of information at the same time.

Please allow the Membership Team approximately two weeks to review applications.

Please contact the Membership Office at (212) 582-0340 x 240 with questions.

Thank you for applying to Fountain House.

Did you remember to include:

1). a current and detailed psychosocial history
2). a current psychiatric assessment

_________________________ Date:_________________________

Prospective Member Signature

_________________________ Date:_________________________

Referral Source Signature

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