

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 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 address above, Attn: Nicole Pickett. If you have questions about HCBS at Fountain House, 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@fountainhouse.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

First: _____ MI: _____ Last: _____
DOB: _____ Age: _____ Gender: _____ SSN: _____ - _____ - _____
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: _____
Email Address: _____ How long have you known this person?
Please check here if you've had a tour of Fountain House. Date of tour: ___/___/___

What is your main goal in joining Fountain House (please choose one)?

Community Education Employment Wellness Benefits/Resources Other:

Why would Fountain House be a good place for you?

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

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 |
| 5). Supported Apt. (Subsidized) | 12). Prison/ Jail |
| 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: \$ _____		

Medical Alerts (circle all that apply)

Deaf/Hearing Impairment Asthma
Recent Surgery Diabetes
Other: _____

Chronic Physical Illness
New Psychiatric Medication
Epilepsy/Seizure Disorder

Severe Allergic Reactions
Blind/Visual Impairment
Hypertension

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): _____
Health and Recovery Plan (HARP)? YES NO
Home and Community Based Services (HCBS)? YES NO

Date of Last Physical Exam: _____ Date of Last Dental Exam: _____

Psychiatric Diagnosis (DSM V): _____

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? Please answer all questions. Your answers will not influence your application Decision

<u>Alcohol</u>		<u>Drugs</u>	
YES	NO	YES	NO

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**

How would you describe yourself with regards to your alcohol/substance use?

Never Used Substances Long-term Sober Recently Sober Moderated Use Frequent Use

Legal History

Please answer all questions

Have you ever been in jail?	YES	NO
Have you ever been in prison?	YES	NO
Have you ever been convicted of a misdemeanor?	YES	NO
Have you had any arrests for felonies?	YES	NO
Have you ever physically injured another person?	YES	NO
Do you have any history of violent behavior?	YES	NO

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

Let us know if you are currently receiving services from any of the following:

Substance Abuse Program Work Program Acces-VR Education Support HARP 35F FW

Other: _____

How well do each of the following statements represent how you *feel* about your current community:

I get important needs of mine met by my current community...

Not at all	Somewhat	Mostly	Completely
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It is important for me to feel apart of a community...

Not at all	Somewhat	Mostly	Completely
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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 ext. 240 with questions.

Thank you for applying to Fountain House.

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 (included on the following page of this application)

Prospective Member Signature Date: _____

Referral Source Signature Date: _____

Substance Abuse Questionnaire

The following is a questionnaire, required by one of our funding sources. Please note that your answers to these questions do not affect your acceptance to Fountain House.

Name: _____ Date: _____

When 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