To Whom It May Concern:

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

1. A Fountain House 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, MSEd, 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 212-582-0340 ext. 240.

Application information can be sent via fax to (212) 664-0750, emailed to membership@fountainhouse.org or sent by mail to:

Fountain House
Attn: Membership Office
425 West 47th Street
New York, NY 10036

Thank You,
The Membership Team

FOUNTAIN HOUSE
Inspiring Communities for Mental Health

MEMBERSHIP APPLICATION

Fountain House 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, as membership is voluntary.
- Have a primary presenting problem associated with severe and persistent mental illness.
- Be able to get to Fountain House.
- 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'ev 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)
2). Home of Family Member
3). Rooming/ Boarding House, Hotel
4). SRO (Temporary)
5). Supported Apt. (Subsidized)
6). 24 Hr. Supervised Housing
7). Supportive Apartment
8). Supervised Housing (Part-time Supervision)
9). Foster Care
10). Psychiatric Hospital
11). Nursing Home
12). Prison/ Jail
13). Shelter
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: $_____________
SSDI: $____________
Wages: $___________
Family/Family Support: $_____
SNAP: $___________________
Retirement Benefits: $________
Veteran's Benefits: $_________________
Public Assistance: $_________________
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 | 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 Level (circle all that apply)

Less than High School | Some High School | GED | High School Diploma
Trade School | Some College | Associate's Degree | Bachelor's Degree
Some Graduate Work | Master's Degree | Advanced Graduate Degree

School Attended	Years	Major	Did you Graduate?

Employment History

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

Please List Most Recent Employments:

Dates	Employer	Title/ Type of work

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):________________

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

Alcohol		Drugs	
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 regrads to your alcohl/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 i ZSf fkbWeaXegbbadfe kag SdWdWh[` YUgdWf'k1:

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

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

It is important for me to feel apart of a community...

Not at all	Somewhat	Mostly	Completely

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)

____ Date:__________________

Prospective Member Signature

____ Date:__________________

Referral Source Signature

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