FOUNTAIN HOUSE
Inspiring Communities for Mental Health

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 documents 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 (917) 426-7985. .

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 Information

First Name:_____ MI:_____ Last Name: _____

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

Phone: _____ Email: _____

Social Security Number:_____-_____-_____

Address

Street:_____Apartment: _____

City:_____ State:_____ Zip Code: _____

County: _____ How long you have lived here: _____

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 Date of tour:_____/____/_____

What is your main goal in joining Fountain House?

☐ Community ☐ Socialize/Friends ☐ 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?

_____
_____
_____
_____
_____
_____

Housing Information

Current Housing Type (choose one):

☐ Own Home/ Apartment (Non-subsidized)	☐ Supportive Apartment
☐ Home of Family Member	☐ Nursing Home
☐ SRO	☐ Shelter
☐ Supported Apt. (Subsidized)	☐ Homeless/ Undomiciled
☐ 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)

☐ SSI: $	☐ Retirement Benefits: $
☐ SSDI: $	☐ Veteran's Benefits: $
☐ Wages: $	☐ Public Assistance: $
☐ Family/Family Support: $	☐ Other: $
☐ SNAP: $	Total Income: $

Ethnicity

(please check all that apply)

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

☐ None	☐ 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	

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)

☐ Chronic Physical Illness	☐ Severe Allergic Reactions
☐ Asthma	☐ New Psychiatric Medication
☐ Blind/Visual Impairment	☐ Deaf/Hearing 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?_____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)

☐ 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):

☐ 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?	☐ YES ☐ NO
Have you ever been in prison?	☐ YES ☐ NO
Have you ever been convicted of a misdemeanor?	☐ YES ☐ NO
Have you ever been convicted of a feloniey?	☐ 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", 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.

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	☐ Not at all	☐ Somewhat	☐ Mostly	☐ Completely
It is important for me to feel a part of a community.	☐ Not at all	☐ Somewhat	☐ Mostly	☐ Completely
How often do you feel that you lack companionship	☐ Hardly Ever	☐ Some of the time	☐ Mostly	☐ Completely
How often do you feel left out?	☐ Hardly Ever	☐ Some of the time	☐ Mostly	☐ Completely
How often do you feel isolated from others?	☐ Hardly Ever	☐ Some of the time	☐ Mostly	☐ Completely

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

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 **(917) 426-7985** 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 and survey (included on the following page of this application)

_____ Date: _____

Prospective Member Signature

_____ Date: _____

Referral Source Signature