NYDIS' Lower East Side Clubhouse

MEMBERSHIP APPLICATION

NYDIS is committed to supporting the recovery of individuals with mental illness by offering opportunities for them to live, work, and learn, all while contributing their skills within a community built on mutual support. Membership is voluntary, free and without time limit. If you're interested in membership, please fill out the application form.

Requirements for Membership:

- *Be interested in attending NYDIS' LES Clubhouse as membership is voluntary.*
- *Have a diagnosis associated with severe and persistent mental illness.*
- *Be able to get to NYDIS' LES Clubhouse.*
- *Not pose a threat to our community.*
- *Be at least 18 years of age.*

To apply for membership please submit the following documentation:

- *Completed NYDIS LES Clubhouse Membership Application.*
- *Completed psychiatric attestation form signed by a licensed mental health professional.*
- *Copies of all Health Insurance cards if you have insurance (insurance not required for membership).*
- *Optional: If you have other documentation (a psychosocial or a psychiatric evaluation) to support the application, please include it.*

Completed Application and supporting documentation can be sent via email to clubhouse@nydis.org, or by visiting NYDIS' LES Clubhouse located at 48 Henry St, New York NY 10002.

This application is solely for NYDIS' LES Clubhouse membership. For any other NYDIS initiatives, please visit our website at www.nydis.org

Prospective Member Information

First Name:_____MI:____Last Name: _____

If you are not known by your legal name, please enter your preferred name below:

_____ Preferred Pronouns: _____

Date of Birth:_____/____/_____ Social Security Number: _____

Gender Identity

☐ Woman	☐ Man
☐ Transgender Woman	☐ Transgender Man
☐ Other Gender	☐ Non-Binary

Race and Ethnicity

☐ Alaskan Native/American Indian	☐ Asian
☐ Latino/Latina	☐ Black/African American (Non-Latino)
☐ Native Hawaiian/Pacific Islander	☐ White (Non-Latino)
☐ Mixed Race	☐ Other

Sexual Orientation

☐ Heterosexual/Straight	☐ Bisexual
☐ Lesbian	☐ Gay
☐ Undisclosed	☐ Other Sexual Orientation

Address

Street: _____Apartment:_____

City: _____State: _____ Zip Code:_____

Landline Phone: _____Mobile Phone: _____

Email: _____ County_____

Housing Type (choose one):

☐ Own Home/Apartment (non-subsidized)	☐ Supportive Apartment
☐ Home of Family Member	☐ Nursing Home
☐ Single Room Occupancy (SRO)	☐ Shelter
☐ Supported Apartment (Subsidized)	☐ Homeless/Undomiciled
☐ 24 Hr. Supervised Housing	

Do you have children under the age of 18 residing in your home? ☐ YES ☐ NO

If YES, is there/has there been an open ACS case? ☐ YES ☐ NO

Do you have a history of homelessness? ☐ YES ☐ NO

If YES, in the past 12 months? ☐ YES ☐ NO

Please explain any homelessness history: _____

_____

_____

_____

Veteran Status: Are you a veteran? ☐ YES ☐ NO

Primary Language, If other than English: _____

Referral Information:

Self-referral: ☐ YES ☐NO... If NO, please fill out referrer information below.

Name of referrer: _____ Phone: _____

Email: _____

Agency Name: _____

Is the referring agency a Mental Health Provider? □ YES□ No

Is this applicant transferring from another clubhouse? □ YES□ No

If yes,initial enrollment date at transferring Clubhouse(estimate is fine)_____

Name of transferring Clubhouse_____

☐ Check if you've had a tour of the Clubhouse

What is your main goal in joining Clubhouse?

☐ Community/Socialization ☐ Education ☐ Employment ☐ Health & Wellness

☐ Benefits/Care Management ☐ Housing ☐ Other

Why would the Clubhouse be a good place for you?

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

Benefits and Entitlements

(Please check all that apply with ID # and $ amounts)

☐ SSI #_____ $_____ Start Date_____ Payee_____	
☐ SSDI #_____ $_____ Start Date_____ Payee_____	
☐ SNAP: $_____	☐ Public Assistance: $_____
☐ Veteran Benefits: $_____	☐ Retirement Benefits: $_____

Medical Insurance

(Not necessary for membership)
Please provide Insurer name and policy number if you have insurance.

☐ Straight Medicaid	Provider:_____	ID #_____	Effective Date:_____
☐ Medicare	Provider:_____	ID #_____	Effective Date:_____
☐ Private	Provider:_____	ID #_____	Effective Date:_____
If Medicaid Managed Care, please include name of managed care company:			

Education

(Please check highest academic level)

☐ No HS diploma/GED/TASC	☐ GED/TASC	☐ High School Diploma
☐ Business, tech or voc training	☐ Some College but no degree	☐ 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**

If NO, have you worked in the last 12 months? ☐**YES** ☐**NO**

If NO, have you ever worked for pay? ☐**YES** ☐**NO**

If Currenly Employed, please select what type of employment

□ Paid competitive full-time (35+ hrs/week) □ Paid Competitive part-time □ Supported Employment □ Transitional Employment □ Temporary, seasonal, or per diem □ Employed (Unknown Details) □ Paid Internship □ Volunteer □ Not employed, looking for employment □ Not employed, not looking for employment □ Not employed (Unknown Details)□ Unknown □ Other

Medical and Health Conditions

(Check all that apply)

☐ Mobility Impairment	☐ Severe Allergic Reactions
☐ Asthma	☐ New Psychiatric Medication
☐ Blind/Visual Impairment	☐ Deaf/Hearing Impairment
☐ Emphysema	☐ Diabetes
☐ Epilepsy/Seizure Disorder	☐ Hypertension
☐ Other:	

Medical & Psychiatric Contacts

Psychiatrist: _____

Agency: _____ Phone: (_____)_____-_____

Address: _____ Email: _____

How long have you been seeing this psychiatrist? _____years_____months

Primary Care Doctor: _____

Agency: _____ Phone: (_____)_____-_____

Address: _____ Email: _____

How long have you been seeing this medical doctor? _____years_____months

Therapist: _____

Agency: _____ Phone: (_____)_____-_____

Address: _____ Email: _____

How long have you been seeing this Therapist? _____years_____months

Emergency Contact

Full name: _____

Phone: (_____)_____-_____ Relationship: _____

Psychiatric Diagnosis (DSM V):

☐ Schizophrenia ☐ Schizoaffective ☐ Major Depressive Disorder ☐ Bipolar

☐ Other: _____

Secondary Diagnosis: _____

Medications

Please list all relevant psychiatric, medical, and chronic health related medications.

Name:________________________	Dosage:__________	Strength:________	Freq: _______	Start Date: ______________
Name:________________________	Dosage:__________	Strength:________	Freq: _______	Start Date: ______________
Name:________________________	Dosage:__________	Strength:________	Freq: _______	Start Date: ______________
Name:________________________	Dosage:__________	Strength:________	Freq: _______	Start Date: ______________
Name:________________________	Dosage:__________	Strength:________	Freq: _______	Start Date: ______________
Name:________________________	Dosage:__________	Strength:________	Freq: _______	Start Date: ______________
Name:________________________	Dosage:__________	Strength:________	Freq: _______	Start Date: ______________
Name:________________________	Dosage:__________	Strength:________	Freq: _______	Start Date: ______________
Name:________________________	Dosage:__________	Strength:________	Freq: _______	Start Date: ______________

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 If YES, in the pat 12 months? ☐ YES ☐ NO

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

Alcohol ☐ YES ☐ NO If YES, in the past 12 months? ☐ YES ☐ NO
Drugs ☐ YES ☐ NO If YES, in the past 12 months? ☐ 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 felony?	☐ YES ☐ NO
Have you ever physically injured another person?	☐ YES ☐ NO
Do you have any history of violent behavior?	☐ YES ☐ NO

Have any of the above occured in the past 12 months? ☐ YES ☐ NO
Please explain any Legal History:

____

____

____

____

Questionnaire and Surveys: *Answers to these questions do not affect your acceptance to Clubhouse.*

Taking everything into consideration, during the past year 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 year?	☐	☐	☐	☐	☐

Please indicate your agreement or disagreement with each of the follow statements using the scale below	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
My life has a clear sense of purpose...	☐	☐	☐	☐	☐
I am optimistic about my future...	☐	☐	☐	☐	☐
My life is going well...	☐	☐	☐	☐	☐
I feel good most of the time...	☐	☐	☐	☐	☐
What I do in life is valuable and worthwhile...	☐	☐	☐	☐	☐
I can succeed if I put my mind to it...	☐	☐	☐	☐	☐
I am achieving most of my goals...	☐	☐	☐	☐	☐
In most activities I do, I feel energized...	☐	☐	☐	☐	☐
There are people who appreciate me as a person...	☐	☐	☐	☐	☐
I feel a sense of belonging in my community...	☐	☐	☐	☐	☐

PLEASE answer the following questions:			
How often do you feel that you lack companionship	☐ Hardly Ever	☐ Some of the time	☐ Often
How often do you feel left out?	☐ Hardly Ever	☐ Some of the time	☐ Often
How often do you feel isolated from others?	☐ Hardly Ever	☐ Some of the time	☐ Often

Signatures and Acknowledgements

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.

Clubhouse operations track and manage data on member utilization of services. Member data and utilization data is used for program evaluation, quality assurance, reimbursement, reporting, and research. Operational data on members and service utilization is deidentified, anonymous, and reported in the aggregate when used for the purpose of external research and projects.

By signing below the prospective member or referrer is attesting to the accuracy of the information contained in this application and acknowledging Clubhouse practices.

_____Date: _____
Prospective Member Signature

_____Date:_____
Referral Source Signature (if applicable)

☐ Check if referral from Clubhouse Enrollment Center (for applicant review team only).

Psychiatric Diagnosis Attestation for NYC Clubhouse Membership

The following must be completed by a licensed professional, (LCSW, LMHC, MD, NP, or similar), for enrollment purposes to a NYC Clubhouse, which utilizes community as a primary tool towards recovery. Its' purpose is to ensure the applicant meets criteria and the clubhouse is a positive, rehabilitative, and safe environment for all.

Name of Applicant: _____ DOB: _____

How long have you known the applicant?: _____

	Current Psychiatric Diagnosis:	ICD 10 Code:
Primary:		
Secondary:		
Tertiary:		
Medical:		

Risk Alerts: No past or current aggressive or violent history (check here) ❑

Please describe any history or current threats of aggression or violence including arson, theft, and inappropriate sexual behavior and how these are being or have been addressed clinically:

_____
_____
_____

Describe the applicant's current needs and challenges:

_____
_____
_____

Describe the applicant's ability to engage in an unstructured community setting:

_____
_____
_____

Describe additional treatment programs or supports the applicant is already receiving or is recommended:

_____
_____
_____

Is there anything else that is important for us to know about the applicant?:

_____
_____
_____

Attestation of Licensed Professional:

Print Name:_____ Date:_____
Signature:_____ License Number:_____
Agency:_____ License Type:_____
Email:_____Phone:_____