

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.

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:

- | | |
|--|--|
| 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: \$ _____		

Ethnicity (check 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: Married Permanent Partner Separated Divorced
Widowed Single, Never Married

Veteran Status Are you a veteran?

Education Level (check 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?

Have you worked in the last 12 months?

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:

Start Date/ End Date	Employer	Title / Type of work	Hourly Wage / Hours per week

Notes:

Medical Alerts (check all that apply)

Deaf/Hearing Impairment

Asthma

Recent Surgery

Diabetes

Chronic Physical Illness

New Psychiatric Medication

Epilepsy/Seizure Disorder

Severe Allergic Reactions

Blind/Visual Impairment

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): _____

HARP (please circle yes or no):

HCBS (please circle yes or no):

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

Please answer all questions.

Alcohol

Drugs

Do you have a history of alcohol or drug abuse?

If an alcohol or substance abuse history exists, please elaborate:

Name of Substance	Date Started	Last Use

Have you ever been in treatment for an alcohol or drug problem?

If so, when and where? _____

Are you currently in treatment or in a support group for alcohol or drug abuse?

If so, when and where? _____

Are you interested in being in treatment or a support group for alcohol or drug abuse?

Legal History

Please answer all questions

Have you ever been in jail?

Have you ever been in prison?

Have you ever been convicted of a misdemeanor?

Have you had any arrests for felonies?

Have you ever physically injured another person?

Do you have any history of violent behavior?

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

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 using the DSM V
- 3). Copies of all health insurance cards
- 4). Substance Abuse Questionnaire

Finally, we have locations in two boroughs. Are you applying to Fountain House Bronx or Fountain House Manhattan? _____

Prospective Member Signature

Date: _____

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?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you ever felt bad or guilty about your drinking or drug use?
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?

CAGE-AID Questionnaire