



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 , 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

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've had a tour of Fountain House. Date of tour: _____

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

Other:

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: \$ _____		

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 " "Married Permanent Partner Separated Divorced
"Widowed Single, Never Married

Children Do you have any children? " If YES, how many? _____

Veteran Status Are you a veteran?

Citizenship Are you a US Citizen/Permanent Resident?

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?

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

It is important for me to feel a part of a community

Employment History

Have you ever worked for pay?

Have you worked in the last 12 months?

Please List Most Recent Employments:

Dates	Employer	Title/ Type of work

Notes:

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:

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)?

Home and Community Based Services (HCBS)?

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

Psychiatric Diagnosis (DSM V):

Medications (please list all medications with respective dosage & frequency)

Name	Dosage	Frequency	Name	Dosage	Frequency
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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:

- 1).
- 2).
- 3).
- 4).
- 5).
- 6).
- 7).
- 8).
- 9).
- 10).

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:
"

"

"

"

*****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.

Let us know what types of supports you are receiving currently?:

Substance Abuse Program

Work Program

Acces-VR

Education Support

ACT Team

Other: _____

Are you applying to Fountain House Manhattan or Fountain House Bronx?

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?
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