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 ŜØl·ftdzl·ûâ2y, 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

Rev: 6/2018

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'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)
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: $ _____ Family/Family Support: $_____ Veteran's Benefits: $_____
SSDI: $_____ SNAP: $_____ Public Assistance: $ _____
Wages: $ _____ Retirement Benefits: $_____ Other: _____

Total Income: $_____

Ethnicity (circle all that apply)

- White / European American
- Asian
- Pacific Islander / Native Hawaiian
- Native American / American Indian

Black / African American

- African American
- Afro-Caribbean
- African Continent
- Other Black
- Unknown
- Not Applicable

Hispanic / Latin American

- Cuban
- Mexican
- Puerto Rican
- Dominican
- South American
- Central American

Other Ethnicity:

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 ☐ Chronic Physical Illness ☐ Severe Allergic Reactions ☐
Recent Surgery ☐ Diabetes ☐ New Psychiatric Medication ☐ Blind/Visual Impairment ☐
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:
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

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).

2).

3).

4).

5).

6).

7).

8).

9).

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)

_____ 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?

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