

Please Circle Clubhouse Name : Diamond Head Friendship House Hale O Honolulu Hale O Lanakila Hale Oluea
Ko'olau Kona Paradise Molokai Waipahu Aloha Date Received: _____

**Prospective Member Application
Hawaii Clubhouse Coalition**

Date of Referral: _____

Name:

First: _____ MI: _____ Last: _____ Client Record # _____

DOB: _____ SSN: _____ Place of Birth: _____ Sex: M F

Street Address:

Street: _____ Apt.: _____

City: _____ State: _____ Zip: _____

How long have you resided there? _____

Mailing Address (if different from above):

Street: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Phone Numbers:

Home: _____ Mobile: _____ Other (please specify): _____

Emergency Contacts:

Primary: _____ Relationship: _____

Address: _____ Phone: _____

Marital Status: _____

Ethnicity (check all that apply): *For statistical purposes only*

African-American Alaskan Native American Indian Caucasian Chinese

Filipino Hawaiian Hispanic Japanese Korean

Middle Eastern Portuguese Puerto Rican Pacific Islander, Other

Samoan Unknown Other (please specify): _____

Primary Language (if other than English): _____

Entitlements (enter monthly amounts for all that apply):

SSI: \$ _____ Veteran's Benefits: \$ _____ DHS: \$ _____

SSDI: \$ _____ Public Assistance: \$ _____ Food Stamps: \$ _____

Other (please specify): \$ _____ Total Monthly Income: \$ _____

SSA Worker: _____ DHS Worker: _____

Veteran Status: Are you a veteran? Yes No

Caseworker: _____ Phone: _____

Medical Alerts (check all that apply):

Asthma Deaf Hearing Impairment Chronic physical Illness

Severe Allergic Reaction New psychiatric medication Epilepsy/seizure disorder

Recent surgery Blind/Visual Impairment Diabetes

Hypertension Other (please specify): _____

Alert Memo: _____

Diagnosis:

Primary Diagnosis: _____ **Diagnosis Code:** _____

Secondary Diagnosis: _____ **Diagnosis Code:** _____

GAF: _____

Psychiatric & Medical Contacts:

Case Manager: _____ Agency: _____ Phone: _____

Psychiatrist: _____ Agency: _____ Phone: _____

How long have you been seeing this psychiatrist? _____

Date of last hospitalization: _____

Therapist: _____ Agency: _____ Phone: _____

How long have you been seeing this therapist? _____

Primary Care MD: _____ Clinic: _____ Phone: _____

Date of last physical examination: _____ Date/Result of last TB test: _____

Medical Insurance (Indicate type and policy #):

Medicaid: _____ Private Insurance: _____

Medicare: _____ Veterans Insurance: _____

Other (please specify): _____

CCS: _____ Worker: _____ Phone: _____

Medications (list all psychiatric and other medications, dosage, and frequency): *Please specify*

Education History: (List highest level of education)

Employment History:

Have you ever worked for pay? Yes No

Have you worked in the last 12 months? Yes No

List Employment History from most recent:

Dates	Employer	Title/Type of Work	Wage

Have you ever been referred to DVR? Yes No

If yes, what was the outcome? _____

Have you ever been referred to or participated in Steadfast Housing Dev. Corp. Supported Employment Program?

If yes, what was the outcome? _____

What do you do during the day now? _____

Why do you think the Clubhouse would be a good place for you? _____

Special needs or behavior concerns:

Conditional Release (CR)

Information: _____

Current Housing Type (check type):

- Independent Family Group Home Care Home Homeless Other _____

Current Housing Status (check all that apply):

- Alone With room/housemate(s) With spouse/partner With parents
 With other adult relative With minor/children Institutional setting

What is your method of transportation to the Clubhouse? _____

Other referrals made: _____

It is very important that all components of this application are absolutely complete. Any missing or incomplete components may delay the application process.

We would like all prospective members to complete this application with the person recommending them. To avoid delays, be sure the application is signed by both the prospective member and the referral source.

Please contact the Membership Coordinator (at the clubhouse of your choice) if you have any further questions.

Did you remember to include:

- A current and detailed psychosocial history
 A current psychiatric assessment
 A current treatment plan
 A copy of current TB test results
 A copy of all insurance cards

I understand that this information (but not my identity) will be shared with members and staff of the Clubhouse Membership Committee to determine my eligibility for the program.

Prospective Member – Print and sign

Date

Referral Source – Print and sign

Date