CLUBHOUSE of Lehigh County
A PROGRAM OF GOODWILL KEYSTONE AREA

To Whom It May Concern:

A Clubhouse offers hope and opportunities for our members to meet their full potential. We operate on proven Standards which have been developed over a two-decade period and are effective in over 330 Clubhouses worldwide. The Clubhouse of Lehigh County strives to provide full and comprehensive psychiatric rehabilitation services to qualifying individuals living with mental illness and residing and receiving services in Lehigh County.

In order to ensure that the goals of the Clubhouse model of psychiatric rehabilitation and those of each member are met, the Clubhouse structure consists of three main components:

1- **UNITS: here our members immerse themselves in the Clubhouse community finding resources to meet individual needs and meaningful activity/tasks.**
2- **RECOVERY GOAL PLAN: defines areas an individual wishes to improve such as vocational, social, educational, community success and self-maintenance.**
3- **PROJECTS/GROUP ACTIVITIES/EVENTS: opportunities for involvement beyond the unit needs to help to round out a person's time at Clubhouse. The Clubhouse offers Social programming scheduled outside of the regular program hours of operation (8am to 4pm).**

The Clubhouse model of psychiatric rehabilitation is not necessarily most effective for all individuals. To be eligible for services a person MUST have a confirmed PRIMARY MENTAL HEALTH DIAGNOSIS. There are five designated diagnoses for eligibility based upon medical records and a psychiatric diagnosis: Schizophrenia, Borderline Personality Disorder, Major Mood Disorder, Schizoaffective Disorder and Psychotic Disorder NOS.

The applicant must be at least 18 years old and have a desire to participate in the program. Also, the applicant may not pose an immediate threat to the safety of the members and will display behaviors that do not disrupt the everyday functioning of the Clubhouse. All other mental and physical diagnoses must be listed as well. All information must be complete, legible and without omissions.

The referral form may be completed in part by the referring agency/case manager. **Page 4 MUST be completed and signed by the applicant's psychiatrist or therapist**. The applicant must sign the last page of the referral form.

Once the application is reviewed, the applicant or designated person will be contacted to schedule orientation. If the application is deferred for any reason, notice of the decision will be given to the applicant or referring party. As soon as orientation is successfully completed, the new member may begin active participation in the program and will be scheduled to complete a goal plan.

Thank you for your cooperation with our referral, enrollment and orientation process. All information will remain confidential and handled with respect. All referrals will be handled in a timely manner. If you have any questions regarding this matter, please do not hesitate to call. Also, please feel free to make copies of the referral form for your own use.

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REFERRALS FOR THE YOUNG ADULT TRANSITION PROGRAM

This program will focus on training, educating and supporting young adults through their transition into adulthood by exploring careers and post-secondary training and educational opportunities. It will also teach job skills, appropriate work and social behaviors and independent living skills.

Eligibility requirements include:

The individual must be 18-21 years of age and reside in Lehigh County.
The individual must be currently enrolled in High School or in a post-secondary education program.
The individual must be diagnosed with a mental illness.

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Membership Referral Form

REFERRAL TYPE:
- ☐ STANDARD CLUBHOUSE MEMBERSHIP
- ☐ MEMBERSHIP/YOUNG ADULT TRANSITION PROGRAMMING
- ☐ MEMBERSHIP/IGNITE Summer Program

Referring Office/Agency: _____

Person Completing the Referral: _____ Phone: _____

Name of Applicant: _____ Date of Birth:_____

Address: _____ Apt. #: _____

City: _____ State: ____ Zip Code:_____ County: _____

Home Phone: _____ Cell Phone: _____

Social Security Number: ____-____-____ Email: _____

Gender:
- ☐ Male
- ☐ Female

Race:
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ White
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other/Not Volunteered by Recipient

To schedule orientation, the Clubhouse should contact:

☐ **Applicant** **Phone Number:** _____

☐ **Other** **Name/Title:** _____ **Phone Number:** _____

Please forward completed application to:

The Clubhouse of Lehigh County,
Attn: Christopher Stout,
1437 West Gordon Street, Allentown, PA 18102
Fax: 610-433-9940
cstout@yourgoodwill.org

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Health Insurance Information

MA Access #: _____ Medical Assistance HMO: _____

Medicare: _____ Medicare HMO: _____

Private Health Insurance Plan: _____

Mental Health Team

Provider Group	Primary Staff/Clinician	Phone Number	Cell Phone Number

Primary Care Providers

Provider Group	Primary Clinician	Address	Phone Number

Please indicate all which apply:

- ☐ Intellectual Disability – If yes, please indicate IQ:_____
- ☐ Learning Disability – Comment: _____
- ☐ Attention Deficit Disorder – Comment: _____
- ☐ Perceptual Impairment – Comment: _____
- ☐ Auditory Impairment – Comment: _____
- ☐ Autism – Comment: _____
- ☐ Visual Impairment – Comment: _____
- ☐ Physical Disabilities – Comment: _____
- ☐ Seizure Disorder – Comment: _____
- ☐ Other Medical Conditions/Allergies – Comment: _____

_____

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Diagnosis Verification

THIS PORTION OF THE REFERRAL MUST BE COMPELTED BY A PSYCHIATRIST OR THERAPIST

Name of Clubhouse Applicant: _____

Name of Psychiatrist/Therapist: _____

Address: _____

_____

Phone: _____

Psychiatric Diagnosis:

AXIS I: _____ Code: _____

AXIS II: _____ Code: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

Psychiatric Medications (name, dose, frequency): _____

_____

_____

Substance Dependent: ☐ Yes ☐ No

Substance Descriptor:
- ☐ Moderate to Severe Substance Abuse
- ☐ Mild Substance Abuse Issue
- ☐ No Current Substance Abuse Issue but has history of substance issue
- ☐ Unknown Substance Abuse Issue

Describe any presence of significant harm to self, others, or property (date/description):_____

_____

_____

Describe any incidents of violence, arrests, prison terms, fire setting: _____

_____

_____

Describe any current legal involvement (DUI, custody, probation, parole, etc.)_____

_____

_____

Signature of Therapist/Psychiatrist: _____ Date: _____

License Number: _____

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Reasons for Referral / Desired Outcomes

For each area of function, rate the applicant's current label using the key below followed by the desired change the applicant wishes to make in the area.

Key	
0 = No Assistance Necessary	2 = Moderate Assistance Necessary
1 = Mild Assistance Necessary	4 = Extensive Assistance Necessary

Function	Level (see Key)	Desired Change
Education		
Social		
Vocational		
Self-Maintenance/ Daily Living Skills		
Self-Maintenance / Managing Illness & Wellness		

Educational History

Level of Education	Name of School	Highest Level Earned	Dates	Diploma/Major
High School/GED				
Trade/Tech				
College				
Other				

Applicant's Signature: _____ Date: _____

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