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.
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
Health Insurance Information

MA Access #: ___________________________ Medical Assistance HMO: ___________________________

Medicare: ___________________________ Medicare HMO: ___________________________

Private Health Insurance Plan: __________________________________________________________

Mental Health Team

<table>
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<tr>
<th>Provider Group</th>
<th>Primary Staff/Clinician</th>
<th>Phone Number</th>
<th>Cell Phone Number</th>
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Primary Care Providers

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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: ________________________________
***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:
### 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
- 1 = Mild Assistance Necessary
- 2 = Moderate Assistance Necessary
- 4 = Extensive Assistance Necessary

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<th>Function</th>
<th>Level (see Key)</th>
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<td>Self-Maintenance/ Daily Living Skills</td>
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<td>Self-Maintenance / Managing Illness &amp; Wellness</td>
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### Educational History

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<th>Highest Level Earned</th>
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<td>Other</td>
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Applicant’s Signature: ________________________ Date: ____________________

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Fax: 610-433-9940
cstout@yourgoodwill.org