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. For transitional age youth, applications may be submitted before an individual turns 18 years old. However, we will not schedule an individual for their orientation until they turn 18 years old.

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 anyone, but Page 4 MUST be completed and signed by a licensed professional. 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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Membership Referral Form

Name of Applicant: _____ Date of Birth:_____

Address: _____ Apt. #: _____

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

Home Phone: _____ Cell Phone: _____

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

PLEASE CHECK ALL THAT APPLY:

Gender:
- ☐ Male
- ☐ Female
- ☐ Non-Binary

Transgender:
- ☐ Yes
- ☐ No

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

Referring Office/Agency: _____ Email: _____

Person Completing the Referral: _____ Phone: _____

Referral Source Address: _____

To schedule orientation, the Clubhouse should contact:

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

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

Please forward completed application to:

Clubhouse of Lehigh County
Attn: Director
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/ Supports Coordination

Provider Group	Primary Contact	Address	Phone Number

Please indicate all which apply:

- ☐ Communication: Primary Language: _____ / Alternative Means: _____
- ☐ Intellectual Disability – If yes, please indicate IQ:_____
- ☐ Traumatic Brain Injury– Comment: _____
- ☐ 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 LICENSED PROFESSIONAL

Name of Clubhouse Applicant: _____

Name of Licensed Professional: _____

Address: _____

_____

Phone: _____

Diagnosis: _____

_____

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 Licensed Professional: _____ 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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