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CROSSROADS ENROLLMENT APPLICATION

**The APPLICANT must complete pages 1-4.*

Please carefully read and print all answers. Please answer all questions completely.

Today's Date:_____

Personal Information

Name: First: _____ M.I.:_____ Last:_____

Preferred Name: _____ Maiden Name: _____

Date of Birth: ____/____/_____ SSN #: _____-_____-_____

Applicant's Mailing Address:_____

City: _____State:_____ Zip: _____

Permanent Address (if different from above)

City:_____State:_____Zip:_____

Phone: ( ) _____ Alternative Phone: ( )_____

GENDER □ Male □ Female □ Other (please specify)_____

ARE YOU A U.S. MILITARY VETERAN? □ Yes □ No

ETHNICITY (CHECK ALL THAT APPLY) □ African American □ American Indian/Native American □ Asian
□ Caribbean □ Caucasian □ Latino/Hispanic □ Middle Eastern □ Pacific Islander

LANGUAGE □ English □ Primary Other (please specify)_____

MARITAL STATUS □ Single (Never Married) □ Widowed □ Permanent Partner □ Divorced
□ Separated □ Married Number of Minor Children:___

REFERRAL TYPE □ Self, Family, Friends □ Private Practitioner (Psychiatrist/MD)
□ Community Mental Health Center □ County/Local Hospital □ Another Clubhouse
□ State Social Services □ County Social Services □ Vocational Rehab □ Shelter for the Homeless
□ Mental Health Court □ Other: _____
Name of Referring Agency:_____

HOUSING TYPE □ Own Home/Apartment (Non-subsidized) □ Home of a Family Member (shared responsibility) □ Home of a Family Member (dependent on family or guardian) □ Temporary Housing
□ Supported Apartment □ Supervised Housing □ Group Home □ Psychiatric Hospital □ Nursing Home
□ Prison/Jail □ Home of a Friend □ Homeless □ Other (please specify):_____

HOUSING STATUS □ Alone □ With Roommate(s)/ Housemate(s) □ With Parent(s)
□ With Other Adult Relative(s) □ With Minor Child(ren) □With Partner
□ With Partner and Child(ren) □ Institutional Setting

HOUSING SATISFACTION □ Very Satisfied □ Somewhat Satisfied □ Neutral □ Somewhat Unsatisfied □ Very Unsatisfied

SOCIAL INTERACTION Do you have a close friend you can talk to? □ Yes □ No

Do you have frequent conflicts with friends (more than once per month)? □Yes □No

Are you satisfied with your family relationships? □Yes □No

Do you have conflicts with your family members (more than once per month)? □Yes □No

Do you feel isolated? □Yes □No

Have you ever been arrested for a misdemeanor? □ Yes □ No If yes, were you convicted? □ Yes □ No

Have you ever been arrested for a felony? □ Yes □ No If yes, were you convicted? □ Yes □ No

If yes, did it involve violence? □ Yes □ No

Please explain: _____
_____

PRIMARY WEEKDAY ACTIVITY □ Independent Employment □ Parenting/Care Taking at Home □ Other Volunteer Work □ School □ Day Program Outside of the Clubhouse □ School-Trade School/College □ In Hospital/House Bound Psychiatric Reasons □ No Structured Daytime Activity

PRIMARY REASON(S) FOR WANTING TO ATTEND CROSSROADS □ Education □ Employment
□ Socialization □ Housing Support □ Food Pantry

FORM OF TRANSPORTATION _____

EDUCATION LEVEL □ Less than High School □ GED □ High School Diploma □ Trade School/Vo Tech
□ Some College □ Associate's Degree □ Bachelor's Degree □ Some Graduate Work □ Master's Degree
□ Advanced Graduate

Are you interested in continuing your formal education? _____

Current Employment

□ Full Time (32 hours per week or more) □ Part Time (Less than 32 hours per week)

□ Day Labor (Selected to work each day at employment agency)

□ Contract Labor (Selected to work on jobs or projects for a limited period of time)

□ No job at this time and I am <u>not</u> looking. □ No job at this time and I <u>am</u> looking for employment

Employment held for longest time period: _____

INCOME SOURCE(S)/TYPE(S) □ Wages-Independent Employment □ Local Assistance (County/State)
□ Wages-Transitional Employment □ Wages-Supported Employment □ Veteran's Benefits
□ Wages-Sheltered Workshop □ Retirement Benefits □ SSI □ SSDI □ Family Support
□ Friend Support □ General Assistance (State) □ No Financial Support □ AFDC □ TANF □ SNAP
□ Other (please specify): _____

**For Housing assistance, income must be verified.*

Total Amount of Monthly Income:_____

What type of work would you like to do?_____

Medical

MEDICAL ALERTS (CHECK ALL THAT APPLY) □ Chronic Physical Illness □ Severe Allergic Reactions
□ Deaf/Hearing Impairment □ New Psychiatric Medication □ Blind/Vision Impairment
□ Recent Surgery □ Epilepsy/Seizures □ Diabetes □ Asthma □ Hypertension
□ Other Physical Disability (please specify):_____

Emergency Contact Information: Name:_____

Relationship to Applicant:_____ Telephone:_____

Treatment Provider: Name:_____
Agency:_____
Address:_____
Telephone:_____ Release? (Y/N):_____

Medical Insurance Policy(ies): Check all that apply.

□ Medicaid □ Veterans Benefits

□ Medicare □ Workers Compensation

□ Medicare, Managed Care □ Family Pay

□ Private Insurance □ Self-Pay (no insurance)

□ Other (please specify):_____

Last Medical Exam

MM/DD/YYYY:_____ 3. Last Dental Exam: MM/DD/YYYY:_____

Nutrition: Number of meals per day:_____ Special dietary needs:_____

Exercise: □ 30 mins. per day □ 30 mins. weekly □ 30 mins. 3 times per week □ no exercise

Are you currently taking prescribed medications? _____yes _____no

Who prescribed the medications?_____

Frequency of Dr. visits? □ Once a month □ Once a week □ As needed □ Other

Are you currently taking any OTC (over the counter) medications, natural remedies or vitamins and minerals? □ Yes □ No

If you are female, are you currently pregnant? □ Yes □ No

Psychiatric History

Total Number of Hospital Admissions:_____ Approximate dates_____

Estimate Total Months of ALL Hospitalizations:_____

Length (months) of LONGEST Hospitalization:_____

To the best of my knowledge the above information is accurate.

Signature of Applicant:_____

Date:_____

Revised 2/19

Pages 5 & 6 must be completed by a treatment provider and signed by the Prescribing/ Diagnostic Physician. Crossroads Clubhouse serves Adults 18 and older with an AXIS I Diagnosis. Members must be at least 6 months sober/drug free with no history of violence.

Name of Applicant (please print):_____ Applicant's DOB_____

1. Primary Diagnosis: □ Schizophrenia □ Major Depression □ Schizoaffective Disorder

□ Bipolar Disorder □ Other Psychotic Disorder □ Other Major Mental Illness

If other was selected, please specify:_____

The Clubhouse Model best serves individuals with diagnoses included in the Schizophrenia Spectrum and other Psychotic Disorders, Bipolar and Related Disorders, Depressive Disorders, and Anxiety Disorders (as presented in DSM V). Our agency continues to use DSM IV due to billing procedures for ODMHSAS and Dept. of Rehabilitative Services.

2. DSM IV Axis I Written Diagnosis:_____Diagnostic Code:_____

3. DSM IV Axis II Written Diagnosis:_____ Diagnostic Code:_____

4. DSM IV Axis III Written Diagnosis:_____Diagnostic Code:_____

5. DSM IV Axis IV Written Diagnosis:_____ Diagnostic Code:_____

6. DSM IV Axis V Written Diagnosis:_____Diagnostic Code:_____

7. History with Alcohol	Yes	No
a) Has applicant had a problem with alcohol?	□	□
b) Does (s)he want help with an alcohol problem?	□	□
c) Has applicant completed treatment for an alcohol problem?	□	□
d) Is applicant currently in treatment or in a support group?	□	□

8. History with Drugs	Yes	No
a) Has applicant had a problem with drugs?	□	□
b) Does (s)he want help with a drug problem?	□	□
c) Has applicant completed treatment for a drug problem?	□	□
d) Is applicant currently in treatment or in a support group?	□	□

Please provide documentation of successful drug/alcohol treatment program

Drug/Alcohol Notes: (Include Type of Drug, Amount, Frequency):_____

9. How long has (s)he been drug/alcohol free?_____

10. Are you aware of any violent behaviors or incidences that the applicant exhibits or has been involved in? □ Yes □ No

If yes, please describe:_____
_____

Referral Source Name and Credentials:_____

<u>Diagnosing/Prescribing</u> Physician: (print name)_____

(signature) _____

Referring Agency:_____Telephone Number:_____

Signature:_____ Date:_____