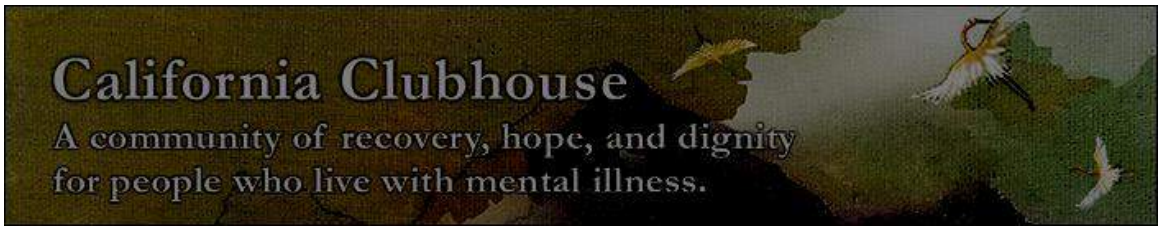


# Membership Eligibility

2205 Palm Avenue, San Mateo CA 94403
650-539-3345
californiaclubhouse.org

California Clubhouse is a membership-based social/vocational community where people living with persistent mental illness come to rebuild their lives. To apply for membership potential applicants need to have one of the following four diagnoses: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder and Major Depressive Disorder. As part of our standards, we also ask about recent history of violent behavior to ensure a safe environment for all members. Members with past accounts of violent behavior or criminal records may still be eligible for membership. As part of our application process, we require a mental health professional/provider to fill this form.

Date: _____ Referred by: _____

Referring Agency: _____

Member's Name: _____

Date of Birth: ____/____/_____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____-_____-_____

MediCal: ___ Yes ___ No ID# _____
Medicare: ___ Yes ___ No ID# _____

Date of last Hospitalization: * _____ Where: _____

Precipitating Factors: * _____

Diagnosis: *

Axis I: _____

Current Medications:_____

_____

(Use back of page or another sheet if necessary)

Axis II: _____

Current Medications:_____

_____

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Axis III: _____

Current Medications:_____

Reason for Referral/Goals: _____

_____

Does member have a history of violent behavior? * ___ Yes ___ No

If Yes, please explain: _____

_____

Any legal involvement? * ___ Yes ___No

If Yes, please explain: _____

_____

Does member have a history/risk of suicide attempts? * ___ Yes ___ No

If Yes, please explain: * _____

_____

Does member have a history of alcohol or drug use? * ___ Yes ___ No

If Yes, please explain: * _____

_____

Does member have access to independent transportation? ___ Yes ___ No

Please explain: _____

_____

Additional Comments:

_____

_____

_____ _____

Signature of Mental Health Care Provider Date

_____ _____

Signature of Member Date

_____ _____

Signature of Clubhouse Date

***MUST BE COMPLETED BY PSYCHIATRIST, MENTAL HEALTH CARE PROVIDER, PHYSICIAN, VRS OR DOR COUNSELOR**

Please attach additional information if necessary.

Edited 9/9/15