**PHOENIX CLUBHOUSE REFERRAL FORM**

*Clubhouse Membership Criteria*

1. *18+ years of age*
2. *History of mental illness*
3. *Membership is open to anyone who does not pose a significant and current threat to the general safety of the Clubhouse Community*
4. *Membership will require individual to have a Mental Health intake completed*

**Referral Organization Information:**

|  |  |  |
| --- | --- | --- |
| Referral Date: | Is the individual aware of the referral?Yes No | |
| Referred by:  Agency/Relationship to individual: | | Referent Phone #: |
| What kind of insurance does the individual have:  Medicaid  Private Insurance :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No Insurance | | |

**Referred Individuals Information:**

|  |  |
| --- | --- |
| Name of referred individual:  Preferred Name:  DOB/Age:  Gender:  Male  Female  Trans-Male Trans-Female  Prefer Not To Answer Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Resident of Lewis County:  yes  no | Address:  Phone:  Email Address: |
| Race:  Caucasian/White  African American  Hispanic Native American/Alaska Native  Bi-Racial/Other race (specify):  Preferred Language: | Highest Grade Level Completed: |
| Does the individual being referred have an existing mental health diagnosis?  Yes  No  Please list any known diagnoses and diagnosis date: | |
| Is the individual already receiving services for mental health?  Yes  No  If yes, where? | |
| Please select the main reason(s) for referral:  Education  Employment  Health & Wellness  Community Events  Healthy Relationships and Self Worth  Purpose & Confidence | |
| Additional Notes: | |