



82 Brigham Street, Marlborough, MA 01752
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www.employmentoptions.org

Referral Application

Enrollment-P.1

Date of Application \_\_\_/\_\_\_/\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ CMHCN: \_\_\_\_\_ SSN: \_\_\_\_\_

Referral Agency - Referral Type

- Self, Family Friends
Private, Practitioner (Psychiatrist/MD)
Community Mental Health Center/Clinic
Another Clubhouse
State Social Services
County Social Services
Sate Vocational Rehab
Supervised Community Services
Public Shelter for the Homeless
Homeless Outreach Team
Police, Courts, Forensic Hospital
Other

Referral Agency

Name: \_\_\_\_\_

Referral Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Referral Notes:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Applicant's Address

Street \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ County/Borough \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Numbers

- Home Business Friend
Parents Fax Other
Beeper Weekend NO Phone

Housing Type

- Own Home/Apartment (Non-Subsidized)
Home of a family member (Shared Responsibility)
Home of family member (Dependent on Family)
Rooming/Boarding House, Hotel
SRO, Temporary Housing
Supported Apartment (Subsidized, Non -Supervised)
Supported Housing (Subsidized, Non Supervised)
Group Home (24 hour Supervision)
Foster Care
Psychiatric Hospital
Nursing Home
Prison/Jail
Shelter
Un-domiciled/Homeless
Other

Ethnicity 1

- African-American Caucasian Caribbean e.g. Haitian, Jamaican
American Indian/Native American Latino e.g. Puerto Rican, Cuban, Mexican Pacific Islander e.g. Samoan Fijian
Asian e.g. Chinese, Japanese, Korean Middle Eastern e.g. Indian, Turkish, Iranian

Description

Height: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Language

- English Primary Other: (please specify) \_\_\_\_\_

Marital Status

- Single Married Widowed Permanent Partner Divorced Separated

Number of Minor Children:

- Custodial Parent Non - custodial Parent

**Primary Reasons for wanting to attend Options Clubhouse** (employment, education, socialization, family services)

1) \_\_\_\_\_  
 2) \_\_\_\_\_  
 3) \_\_\_\_\_

**Medical Alerts**

- Chronic Physical Illness
- Asthma
- Recent Surge
- Epilepsy/Seizure
- Blind/Vision Impairment
- Other Physical Disability
- Diabetes
- New Psychiatric Medication
- Deaf/Hearing Impairment
- Severe Allergic Reaction
- Hypertension
- Other \_\_\_\_\_

**Special Medical Conditions and Allergies**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medical and Psychiatric Contacts** (fill in as appropriate and include address and phone number.)

Provider	Name	Agency	Town/City	Phone Number(s)	Release
Therapist:					<input type="checkbox"/> Yes
Psychiatrist:					<input type="checkbox"/> Yes
DMH Case Manager:					<input type="checkbox"/> Yes
Primary Care:					<input type="checkbox"/> Yes
Other:					<input type="checkbox"/> Yes
Other:					<input type="checkbox"/> Yes

**Emergency Contacts:**

Name	Relationship	Street Address	Town/City, Zip	Phone	Alt. Phone

**History with Drugs**

Has applicant had a problem with drugs?    Yes     No

**How long has he/she been clean and sober?** \_\_\_\_\_

**Drug/Alcohol Notes:** (include Type of Drug Amount and Frequency.)

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**Legal History**

Has applicant ever been in jail?     Yes     No

On probation?     Yes     No

Has applicant ever been convicted of a misdemeanor?     Yes     No

Has applicant ever had any arrest for felonies?     Yes     No

What felonies? (check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Bad Checks/Shoplifting        | <input type="checkbox"/> Manslaughter/Negligent/Homicide | <input type="checkbox"/> Other Crimes of Dishonesty |
| <input type="checkbox"/> Physical abuse/Assault        | <input type="checkbox"/> Robbery/Breaking and Entering   | <input type="checkbox"/> Sexual Misconduct          |
| <input type="checkbox"/> Stealing/Forgery/Embezzlement | <input type="checkbox"/> Rape/Murder                     | <input type="checkbox"/> other _____                |

Has applicant ever physically injured another person?     Yes     No

Does he/she have a history of violent behavior towards others?     Yes     No

Is there any reason this person should not use Employment Options transportation or ride in an Employment Options van?

No     Yes (explain)

**Legal History Notes** (dates, behaviors, precipitants, legal action, etc.) **(Please elaborate on any aggressive behaviors)**

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**Psychiatric Information**

	Written Diagnosis	Diagnostic Code
DSM IV Axis I		
DSM IV Axis II		
DSM IV Axis III		
DSM IV Axis IV		
DSM IV Axis V		

**Psychiatric History**

Total Number of Hospital Admissions \_\_\_\_\_

Estimate Total Months of ALL Hospitalizations \_\_\_\_\_

Length (months) of LONGEST Hospitalization \_\_\_\_\_

Applicant in which hospitals? (List all names, and locations please) \_\_\_\_\_

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**This application must be signed by Referral Source even if filled out by potential member.**

\_\_\_\_\_  
Referral Source Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Referral Source Name