

# Commonwealth of Massachusetts

## DEPARTMENT OF MENTAL HEALTH

### Clubhouse Request for Enrollment Form

Please complete this form and send to [Clubhouseservices@MassMail.State.Ma.US](mailto:Clubhouseservices@MassMail.State.Ma.US). This form is required for a prospective member that was NOT referred by DMH, an inactive member who is seeking to have active membership reinstated, or to request reauthorization of an active membership.

<b>Indicate Referral Type:</b>	
<input checked="" type="checkbox"/>	<b>New Request</b>
<input type="checkbox"/>	<b>Re-activation</b> <i>(Please include current Action Plan with request form)</i>
<hr/>	
<b>To:</b> Clubhouseservices@MassMail.State.Ma.Us	<b>From:</b> centerclub@baycove.org
<b>Clubhouse Services Name:</b> Center Club	<b>Agency:</b> Bay Cove Human Services
Mailing Address: 31 Bowker Street, Boston, MA 02114	
Phone Number: 617-788-1002	E-mail Address: centerclub@baycove.org
<b>Date Form Sent to DMH:</b>	

**The following individual has requested Clubhouse Services and we have determined that the individual meets the Clubhouse Services Criteria** *(The following information is required):*

<b>Name:</b>		<b>Phone#:</b>
<b>Social Security #:</b>	<b>D.O.B.:</b>	<b>Gender:</b>
<b>Address:</b>		
<hr/>		
<b>Language Preference:</b>		
<b>MassHealth Policy#</b> <i>(If applicable):</i>		
<b>Name of Emergency Contact or Legally Authorized Representative (LAR)</b> <i>(If applicable):</i>		
Address:		
Phone Number:		

#### DIAGNOSIS:

<b>Date of Diagnosis:</b>	<b>Clinician:</b>
<b>Axis I</b>	
<b>Axis II</b>	
<b>Axis III</b>	
<b>Axis IV</b>	
<b>Axis V</b>	

#### PHYSICAL HANDICAPS: *(Please Check One or More of the Options Below):*

√	Description	√	Description	√	Description
<input type="checkbox"/>	Blind, Legally < 20/200	<input type="checkbox"/>	Hard of Hearing/Impaired	<input type="checkbox"/>	Semi-Ambulatory, Cane/Crutch
<input type="checkbox"/>	Blind, Total Loss of Vision	<input type="checkbox"/>	Medical Condition Serious/Chronic	<input type="checkbox"/>	Other Impairment Not Listed
<input type="checkbox"/>	Deaf, Severe to Profound	<input type="checkbox"/>	Non-Ambulatory, Wheelchair	<input type="checkbox"/>	None or Unknown

Clubhouse Program Manager Signature	
<b>Requested Enrollment Start Date:</b>	
Mary Gregorio <i>Clubhouse Program Manager</i>	<i>Date</i>

#### **Confidentiality Notice: Protected Health Information**

*Important Warning: This message is intended only for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, the disclosure, copying or distribution of this information is strictly prohibited. If you have received this message in error, please notify the sender immediately.*