**Application for Center Club**

31 Bowker Street, Boston, MA 02114

617-788-1000 | 617-788-1080 (fax) | Email: fmugenyi@baycove.org

**Purpose**: Center Club is a rehabilitation program for men and women with a psychiatric disability.

**Eligibility**: Any person 18 years old or older with a mental health diagnosis who lives in the DMH Metro Boston Area (Boston, Brookline, Cambridge, Chelsea, Revere, Somerville, and Winthrop) is eligible for Center Club.

**How to Request membership in Center Club**: This application form should be filled out by the applicant’s mental health provider (for example, DMH case manager, therapist, psychiatrist, residential program director, ACCS Worker). The Application should be signed by the referring person and the applicant. The attached Authorization for Release of Information should be signed by the applicant. These forms should be sent to the Center Club Intake Coordinator (US Mail, fax or email).

**Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Last Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender** \_\_\_\_\_\_\_\_\_\_\_\_ **Language Preference** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred by** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Title** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Agency** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you a veteran?** Yes\_\_ No\_\_ **Are you a registered voter?** Yes\_\_ No\_\_

**Mental Health Providers** and **Primary Care Physician (PCP):**

|  |  |  |
| --- | --- | --- |
| **Name/Title** | **Agency/Address** | **Telephone** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Reasons for Referral to Center Club:**

|  |
| --- |
| *Please check the appropriate reason for* referral |
| **☐** Employment- Getting a job or keeping my job, employment support |
| **☐** Education- My education |
| **☐** Life Skills -Participate in life skills (budgeting, cooking etc.): Working in a clubhouse work unit. |
| **☐** Health and Wellness-My health and Wellness (eating a meal, DRA, etc.) |
| **☐** Social and recreation-Participating in social, peer support and cultural activities |
| **☐** Accessing Community Linkages- Connecting with community resources |
| **☐** Housing- Work on my housing. Applying for or maintaining my housing |

**Social Security #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Are you a DMH client?** Yes \_\_\_\_No\_\_\_\_

**If you are, please check the DMH site where you get services:**

|  |  |
| --- | --- |
| **√** | **DMH Site** |
|  | Lindemann/Cambridge-Somerville Site (BLS) |
|  | Massachusetts Mental Health Center Site (BMS) |
|  | Fuller/Bay Cove Site (BFS) |

|  |  |
| --- | --- |
| **Diagnoses: Psychiatric and Non Psychiatric** | |
| **Code** | **Description** |
|  |  |
|  |  |
|  |  |
|  |  |

**Medication: Psychiatric and Non Psychiatric:***Attach extra sheet if more space is necessary*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Medication** | | **Dose** | **Frequency** | | |
|  |  | | |  |
|  |  | | |  |
|  |  | | |  |
|  |  | | |  |
|  |  | | |  |
|  |  | | |  |

**Risk Assessment:** *This page should be filled out by the applicant together with the referring person.*

**Situations of Risk (please check all that apply):**

*Please do not leave this page blank.*

**1. No situations of risk ☐**

**2. Situations of risk:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **√** | **Situations of Risk** | **Description** | **Past Problem (date)** | **Problem within past two years** |
|  | Aggressive/Assaultive Behavior |  |  |  |
|  | Homicidal Behavior |  |  |  |
|  | Problematic Sexual Behavior |  |  |  |
|  | Involvement with the Criminal Justice System |  |  |  |
|  | Auditory/Visual Hallucinations |  |  |  |
|  | Suicidal Ideation/Attempt |  |  |  |
|  | Substance Abuse (specify) |  |  |  |

*If the applicant has had a past or a current problem with any of the behaviors listed above, or if the applicant has a current or past involvement with the criminal justice system, please attach a written account of the problematic behaviors or involvement with the criminal justice system (include contact information for probation or parole officers). Center Club is a rehabilitation program and not a clinical program. And yet occasions arise when it is helpful for us to know some things about a person’s experiences that may put them at risk.*

**Comments:**

**Name of Emergency Contact or Legally Authorized Representative (LAR):**

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant’s Signature**

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

**Service Provider’s Signature**

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

#### Center Club

# A program of

#### Bay Cove Human Services

**AUTHORIZATION FOR RELEASE OR REQUEST OF INFORMATION BETWEEN CENTER CLUB STAFF MEMBERS AND MEMBERS OF THE REHABILITATION/TREAMENT TEAM**

I authorize Center Club to obtain information from, forward my confidential records or hold general discussions about my rehabilitation/treatment with members of my treatment/rehabilitation team.

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (This consent is valid for one year from this date)

# Rehabilitation/Treatment Team Members (for example, therapist, psychiatrist, residential program director, ACCS worker)

# 

|  |  |
| --- | --- |
| Name and Title | Agency |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Member/Guardian Signature:**

**Date:**

**Please Print Name:**

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

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

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

**Signature of Person Obtaining Authorization:**

**Date:**

**Please Print Name and Title:**

Florence Mugenyi, Intake Coordinator **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**