Employment Options, Inc.

82 Brigham Street, Marlborough, MA 01752

www.employmentoptions.org

Membership Referral Application

Please print clearly in pen

Tel. (508) 485-5051 x230
Fax. (508) 485-8807 attn. INTAKE
E-Mail: newmember@employmentoptions.org

Date of Application:_____/_____/_____ **First Name**:_____MI: _____ **Last Name**: _____

Date of Birth:_____/_____/_____ Email: _____ SSN:_____

I. 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:_____**City:**_____

Referral Contact:_____**Phone:** _____

Referral Notes: _____

_____

There is more room on Pg. 4

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

1)_____2)_____3) _____

II. Applicant Contact Information Address and Phone Numbers

A) Address Street:_____Apt. #_____

City:_____Zip Code:_____

B) Phone Numbers:

□ Home_____ □ Business_____

□ Cell_____ □ Other_____ □ Fax_____

□ Parents_____ □ NO Phone _____

Needs Transportation: ΔYes ΔNo
Our club can provide/request transportation to:
- Ashland
- Framingham
- Hopkinton
- Hudson
- Marlborough
- Natick
- Northborough
- Southborough
- Westborough

III. Additional Applicant Information

A) Ethnicity:

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

B) Description:

Height:_____ Hair Color:_____ Eye Color:_____

C) Language:

□ English □ Primary Other: _____

C) Marital Status:

□ Single □ Married □ Widowed □ Permanent Partner □ Divorced □ Separated

D) Number of Minor Children:_____ □ Custodial Parent □ Non – Custodial Parent

E) 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

IV. Medical Information

A) Medical Alerts

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

B) Special Medical Conditions and Allergies (***Please*** *note anything that would be helpful for us to know for the applicant's safety*.)

_____

_____

_____

V. Contacts

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

Provider	Name	Agency	Town/City	Phone Number(s)	Release
Therapist:					□ Yes
Psychiatrist:					□ Yes
DMH Case Manager:					□ Yes
Primary Care:					□ Yes
Natural Support:					□ Yes
Other _____					□ Yes

B) Emergency Contacts:

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

VI. History

A) History with Drugs:

1. Has applicant had a problem with alcohol/drugs? □ Yes □ No
2. How long has he/she been clean and sober? _____
3. Drug/Alcohol Notes: (include type of drug, amount, and frequency.)

_____

_____

B) Legal History

1. Has applicant ever been in jail? □ Yes □ No
2. On probation? □ Yes □ No
3. Has applicant ever been convicted of a misdemeanor? □ Yes □ No
4. Arrested for any felonies? □ Yes □ No
5. What felonies? (check all that apply)
   - □ Bad Checks/Shoplifting
   - □ Manslaughter/Negligent/Homicide
   - □ Other Crimes of Dishonesty
   - □ Physical abuse/Assault
   - □ Robbery/Breaking and Entering
   - □ Sexual Misconduct
   - □ Stealing/Forgery/Embezzlement
   - □ Rape/Murder
   - □ Other _____
6. Has applicant ever physically injured another person? □ Yes □ No
7. Does he/she have a history of violent behavior towards others? □ Yes □ No
8. 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)**

_____

_____

VII. Psychiatric Information

A. Diagnosis

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

List of Current Medications (type and amount):

_____

_____

_____

B. Psychiatric History

1. Total Number of Hospital Admissions **due to psychiatric conditions** _____

2. Estimate Total Months of ALL Hospitalizations_____ 3. Length (months) of LONGEST Hospitalization_____

4. Applicant in which hospitals? (List all names and locations please) _____

_____

_____

This application MUST BE SIGNED BY A LICENSED MENTAL HEALTH PRACTITIONER even if filled out by potential member.

_____ _____ _____

Referral Source Signature **Referral Source Name (Print)** **Date**

VIII. Additional Page

Please use this space to elaborate on any question if needed.
Also, include anything that will be helpful for us to know about the potential member to help make the transition easier.

Employment Options, Inc.

Believe in Better

Through inspiration, support and encouragement,
Employment Options creates a home-away-from-home,
where people can overcome barriers to employment
and discover personal growth, self-sufficiency and hope.

Authorization for Release of Information

(Please copy as needed for additional releases for other doctors or clinical workers)

Name:_____

Address: _____

Telephone:_____Date of Birth: _____

I authorize the following person/agency to release the information indicated below to:

Employment Options
82 Brigham St.
Marlborough, MA 01752
Phone: 508-485-5051
Fax: 508-485-8807

Name:_____Telephone: _____

Name of Agency: _____

Address: _____

Specific information to be released:

___ Verbal/Telephone Update ___Admission/Treatment/Discharge Summary

___ Other: _____

Signature:_____

Date of release:_____Date release expires:_____(1 year later)