



## CLUBHOUSE MEMBERSHIP APPLICATION

CHRIS Kids' , along with the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), are partnering to provide integrated treatment, case management, education, and pre-vocational services to adolescents, young adults, and their families. The Clubhouse provides structured, daily activities for adolescents and young adults, with a diagnosed emotional and/or behavioral disorder, between the ages of 16-21. These services are designed to improve the members' psychosocial, educational, vocational, and cognitive skills so that transition into adulthood, self-sufficiency, the community, and society is successful.

### APPLICANT INFORMATION

|   |  |  |
|---|--|--|
| Date of Application:  | Name:  |  |
| SSN:  | Email Address:   |  |
| Date of birth:  | Phone (Home):  | Phone (Cell):  |
| Current address:  |  |  |
| City:   | State/County:  | ZIP Code:  |
| Who do you reside with?   | Is this your parent, caretaker, or legal guardian?   | Relationship Status: (Check One)<br><input type="checkbox"/> Single<br><input type="checkbox"/> Married<br><input type="checkbox"/> Divorced<br><input type="checkbox"/> Never Married |
| Number of Children:<br><input type="checkbox"/> One Age _____<br><input type="checkbox"/> Two Age _____<br><input type="checkbox"/> Three Age _____<br><input type="checkbox"/> _____ | If Applicable, Name of Child (ren):<br>_____<br>_____<br>_____   | If Applicable, Name of Child (ren):<br>_____<br>_____<br>_____   |
| If applicable, do you have childcare?   | Do you need transportation to and from Clubhouse?<br><br><input type="checkbox"/> Yes<br><input type="checkbox"/> No | If yes, are you familiar /know how to utilize Marta system?<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No   |

### LEGAL GUARDIAN INFORMATION (IF APPLICANT UNDER 18 Y/O)

|          |                                 |
|----------|---------------------------------|
| Name:    | Relationship to Applicant:      |
| Address: | Does applicant reside with you? |



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|                      |                     |             |
|----------------------|---------------------|-------------|
| Phone (Home):        | Phone (Cell):       | E-mail:     |
| City:                | State:              | ZIP Code:   |
| Place of Employment: | Employment Address: | Work Hours: |

### MENTAL/BEHAVIORAL HEALTH HISTORY

|  |                      |                     |
|--|----------------------|---------------------|
| <b>Date of Most Current Psychological:</b>                                 | <b>GAF Score:</b>    | <b>CAFAS Score:</b> |
| <b>Diagnosis:</b>  | <b>Medications:</b>  | <b>Dosage</b>       |
| Axis I:  |                      |                     |
| Axis II:   |                      |                     |
| Axis III:  |                      |                     |
| Current Mental Health Service Provider (Doctor, Therapist, Social Worker): |                      |                     |
| Address & Phone Number of Agency:  |                      |                     |
| <b>History of Previous Hospitalizations:</b>                               |                      |                     |
| Entry Date & Location  | Precipitating Events | Date of Discharge   |
|  |                      |                     |
|  |                      |                     |

**Substance Abuse History:**



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Check if you have used any of the following:

- Alcohol
- Cocaine
- PCP
- Marijuana
- Methamphetamines
- Heroin
- Cigarettes
- Other  
(specify) \_\_\_\_\_

Describe history of use; at what age did you start? Are you still continuing? Have you had any sober time?

Have you had to seek treatment for drug use?

- No
- Yes If yes, date and name of agency: \_\_\_\_\_

### **Criminal History**

Legal/Criminal History

- No
- Yes (Describe, dates and cause)

History of Violence

- No
- Yes (Describe, dates and cause)

Are you on probation?

- No
- Yes (Describe, dates and cause)

If on probation, provide probation officer's name and contact info:

### **EDUCATION INFORMATION**

Current school of enrollment:

Date Started:

Grade Level:

Expected Date of Completion:



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If not in school, last Grade Level Completed & Name of Last School of Enrollment:

What educational goal would you like to obtain: (check all that apply):

- GED
- HS Diploma
- Associate/Bachelor Degree
- Technical Trade
- Other (specify)

### EMPLOYMENT INFORMATION

Current/previous employer:

Employer address:

How long?

Start Date:

End Date:

Phone:

E-mail:

City:

State:

ZIP Code:

Position:

Additional Jobs (Employer, Dates of Employment)

If not employed or underemployed (inadequate hours/pay), what employment goals would you like to obtain (check all that apply):

- Part-time
- Full-time
- Internship
- Resume/Application Assistance
- Vocational Trade
- Armed Services (Army, Air Force, Marines, Navy, National Guard, etc.)
- Other (specify)

### MEDICAL INFORMATION

Primary Physician Name & Address:

Phone

Primary Clinician Name & Address:

Phone



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|  |  |  |
|--|--|--|
| <p>Do you have any food allergies?</p> <p><input type="checkbox"/> No<br/><input type="checkbox"/> Yes (specify)</p><br><p>Do you any any other allergies?</p> <p><input type="checkbox"/> No<br/><input type="checkbox"/> Yes (specify)</p> | <p>Do you have any communicable diseases?</p> <p><input type="checkbox"/> No<br/><input type="checkbox"/> Yes (specify)</p><br><p>Do you have any illness that is managed by medication?</p> <p><input type="checkbox"/> No<br/><input type="checkbox"/> Yes (specify)</p> | <p>Check all that you receive:</p> <p><input type="checkbox"/> Medicaid</p> <p>If yes, Medicaid No: _____</p><br><p><input type="checkbox"/> SSI<br/><input type="checkbox"/> SSDI<br/><input type="checkbox"/> Private Insurance</p> <p>Provider: _____</p><br><p>Group No: _____</p> |
|--|--|--|

| <b>Prescription Medications</b> |                |               |
|---------------------------------|----------------|---------------|
| <b>Medication</b>               | <b>Purpose</b> | <b>Dosage</b> |
|                                 |                |               |
|                                 |                |               |
|                                 |                |               |
|                                 |                |               |
|                                 |                |               |

| <b>SIGNATURES</b>   |       |
|---|-------|
| Signature of applicant:   | Date: |
| Signature of guardian ( <i>only if applicant under 18 years of age</i> ): | Date: |