IRIS CLUBHOUSE

The Iris Clubhouse is dedicated to the recovery of people living with mental illness by providing opportunities for members to live, work, and learn, while contributing their talents through a community of mutual support.

By working together, members regain confidence, make friends, learn new skills, and make progress towards achieving their employment, social and educational goals. Membership is voluntary, free and without a time limit. If you're interested in membership, please fill out the application, or call the Iris Clubhouse at 307-333-2507 or email outreach@irisclubhouse.org.

Requirements for Membership:

- [ ] Be interested in attending Iris Clubhouse, as membership is voluntary.
- [ ] Have a diagnosable mental illness or be willing to seek a diagnosis
- [ ] Not pose a threat to our community.
- [ ] Be at least 18 years of age.

To apply for membership please submit the following documentation:

- [ ] Completed Iris Clubhouse Membership Application.
- [ ] Completed psychiatric attestation form signed by a licensed mental health professional.
- [ ] Copies of all Health Insurance cards if you have insurance (insurance not required for
- [ ] membership).
- [ ] Optional: If you have other documentation (a psychosocial or a psychiatric evaluation) to support the application, please include it.

Complete Applications and supporting documentation can be sent via email to outreach@irisclubhouse.org.

Prospective Member Information

Member Account #:

Member Personal Information

First Name, MI, Last Name :	
If you are not known by your legal name, please enter your preferred name	
Preferred Pronouns	
Date of Birth (MM/DD/YYYY):	
Social Security Number:	
Medicaid ID Number (10 digits):	
Address:	
Phone Number:	
Secondary Phone Number:	
Email Address:	

Gender Identity

☐ Woman	☐ Man
☐ Transgender Woman	☐ Transgender Man
☐ Other Gender	☐ Non-Binary

Race and Ethnicity

☐ Alaskan Native/American Indian	☐ Asian
☐ Latino/Latina	☐ Black/African American (Non-Latino)
☐ Native Hawaiian/Pacific Islander	☐ White (Non-Latino)
☐ Mixed Race	☐ Other

Sexual Orientation

☐ Heterosexual/Straight	☐ Bisexual
☐ Lesbian	☐ Gay
☐ Undisclosed	☐ Other Sexual Orientation

Veteran Status: Are you a veteran? ⬜ YES ⬜ NO

Primary Language, If other than English: ____

Referral Information

Self-Referral: ⬜ YES ⬜ NO … If NO, please fill out referrer information below.

Name of referrer:_________________________ Phone: _____________________________

Email: ____

Agency Name: ____

⬜ Check if you've had a tour of the Clubhouse

Member Medical Information

☐ **Mobility Impairment**	☐ **Severe Allergic Reactions**
☐ **Asthma**	☐ **New Psychiatric Medication**
☐ **Blind/Visual Impairment**	☐ **Deaf/Hearing Impairment**
☐ **Emphysema**	☐ **Diabetes**
☐ **Epilepsy/Seizure Disorder**	☐ **Hypertension**
☐ **Other:**	

Medications

Please list all relevant psychiatric, medical, and chronic health related medications.

Name:____________________ Dosage:__________Strength:_______Freq:_____ Start Date:________
Name:____________________ Dosage:__________Strength:_______Freq:_____ Start Date:________
Name:____________________ Dosage:__________Strength:_______Freq:_____ Start Date:________
Name:____________________ Dosage:__________Strength:_______Freq:_____ Start Date:________
Name:____________________ Dosage:__________Strength:_______Freq:_____ Start Date:________
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Name:____________________ Dosage:__________Strength:_______Freq:_____ Start Date:________
Name:____________________ Dosage:__________Strength:_______Freq:_____ Start Date:________
Name:____________________ Dosage:__________Strength:_______Freq:_____ Start Date:________

Do you regularly take your prescribed medications? **Do you need assistance to regularly take your prescribed medications?**	☐Yes ☐No ☐Sometimes ☐Yes ☐No
Allergies, *if applicable*: ***Please include any medication allergies and/or food allergies.***	
Do you have any physical limitations? **If so, please explain:**	☐Yes ☐No

Member Mental Health History

Primary Mental Health Diagnosis: **Secondary Mental Health Diagnosis:**	☐ Schizophrenia ☐ Bipolar Disorder ☐ Schizoaffective Disorder ☐ Major Depression ☐ Other
Do you have a history of violent behavior? ***If yes, please explain.***	☐Yes ☐No
Do you have a history of suicide attempts? ***If yes, please explain.***	☐Yes ☐No
Do you have an active crisis management plan? ***If so, would you be willing to provide a copy of your crisis management plan to the Clubhouse to have on record?***	☐Yes ☐No ☐Yes ☐No ☐ N/A
Do you have a history of alcohol and/or drug abuse? **If yes, in the past 12 months?** ***If yes, please explain.***	☐Yes ☐No ☐Yes ☐No
Do you have a history of sexual misconduct? ***If yes, please explain.***	☐Yes ☐No
Are you currently in outpatient mental health treatment? ***If yes, please note your provider and frequency of your current treatment.***	☐Yes ☐No
Have you ever been hospitalized related to your mental health condition? ***Date of Most Recent Hospitalization:***	☐Yes ☐No
Have you ever been in jail? **Have you ever been in prison?** **Have you ever been convicted of a misdemeanor?** **Have you ever been convicted of a felony?**	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No

Have you ever physically injured another person? **Do you have any history of violent behavior?** **Have any of the above occurred in the past 12 months?** ***If yes, please explain.***	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No

Member Contacts

Emergency Contact: Full Name: Relationship: Phone Number:	
Primary Care Doctor Name: Agency: Phone Number: Address Email How long have you been seeing this medical doctor?	____________Years ____________ Months
Psychiatrist: Agency: Phone Number: Address Email How long have you been seeing this psychiatrist?	____________Years ____________ Months
Behavioral Health Provider Name: Phone Number:	
Therapist Name: Agency: Phone Number: Address Email How long have you been seeing this psychiatrist?	____________Years ____________ Months

Case Worker Name: Phone Number:	
Guardian Name, *if applicable*: Phone Number:	

Member Personal Background

Are you employed? **If Yes, date of current employment** **If no, have you worked in the last 12 months?** **If no, have you ever worked for pay?** **Are employment related goals of interest to you as a Clubhouse member?**	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No
What is your educational background? **Are education related goals of interest to you as a Clubhouse member?**	☐None ☐ GED ☐Some High School ☐High School Diploma ☐ Trade School ☐ Some College ☐ Associate's Degree ☐ Bachelor's Degree ☐ Some Graduate Work ☐ Master's Degree ☐ Advanced Graduate Degree ☐Yes ☐No
What is your current housing situation? **Are housing related goals of interest to you as a Clubhouse member?**	☐ Own Home/Apartment ☐ Supportive Apartment ☐Supported Apartment (Subsidized) ☐ Unhoused ☐ Single Room Occupancy (SRO) ☐ Shelter ☐ 24 Hr. Supervised Housing ☐ Nursing Home ☐ Live with Relatives/Friends ☐ Boarding Home ☐Yes ☐No

Do you have children under the age of 18 residing in your home? ☐ YES ☐ NO

If YES, is there/has there been an open ACS case? ⬜ YES ⬜ NO

Do you have a history of homelessness? ⬜ YES ⬜ NO

If YES, in the past 12 months? ⬜ YES ⬜ NO

Please explain any homelessness history:

____

____

____

Member Potential Goals

To be completed with the assistance of a Clubhouse staff member.

Does the member have potential goals related to medication management?	☐Yes ☐No
Does the member have potential goals related to employment?	☐Yes ☐No
Does the member have potential goals related to education?	☐Yes ☐No
Does the member have potential goals related to housing?	☐Yes ☐No

What is your main goal in joining the Iris Clubhouse?

⬜ Community/Socialization ⬜ Education ⬜ Employment ⬜ Health & Wellness
⬜ Benefits/Care Management ⬜ Housing ⬜ Other

Why would the Clubhouse be a good place for you?

What challenges or barriers are keeping you from achieving your goals?

Benefits and Entitlements

(Please check all that apply with ID # and $ amounts)

☐ SSI #____________$_________ Start Date___________Payee______________________	
☐ SSDI #____________$_________ Start Date___________Payee_____________________	
☐ SNAP: $_________________________	☐ Public Assistance: $_______________
☐ Veteran Benefits:$________________	☐ Retirement Benefits: $_____________

Medical Insurance

(Not Necessary for membership)

Please provide Insurer name and policy number if you have insurance

☐ Medicaid ID# _____________ Effective Date:_________ ☐ CCW Waiver ☐ DD Waiver
☐ Medicare Type:__________ ID#___________ Effective Date:____________
☐ Private Type:____________ ID#____________ Effective Date:__________

IRIS CLUBHOUSE

Questionnaire and Surveys: *Answers to these questions do not affect your acceptance to Clubhouse.*

Taking everything into consideration, during the past year how satisfied have you been with your…	Very Poor	Poor	Fair	Good	Very Good
…physical health?	☐	☐	☐	☐	☐
…mood?	☐	☐	☐	☐	☐
…work?	☐	☐	☐	☐	☐
…household activities?	☐	☐	☐	☐	☐
…social relationships?	☐	☐	☐	☐	☐
…family relationships?	☐	☐	☐	☐	☐
…leisure time activities?	☐	☐	☐	☐	☐
…ability to function in daily life?	☐	☐	☐	☐	☐
…economic status?	☐	☐	☐	☐	☐
…living/housing situation?	☐	☐	☐	☐	☐
…ability to get around physically without feeling dizzy or unsteady or falling?	☐	☐	☐	☐	☐
…your vision in terms of ability to do work or hobbies?	☐	☐	☐	☐	☐
…overall sense of well-being?	☐	☐	☐	☐	☐
…medication? (if not taking any, check here ☐ and leave item blank).	☐	☐	☐	☐	☐
…How would you rate your overall life satisfaction and contentment during the past year?	☐	☐	☐	☐	☐

Iris Clubhouse

Please indicate your agreement or disagreement with each of the following statements using the scale to the right.	Strongly Disagree	Disagree	Neither agree or Disagree	Agree	Strongly Agree
My life has a clear sense of purpose…	☐	☐	☐	☐	☐
I am optimistic about my future…	☐	☐	☐	☐	☐
My life is going well…	☐	☐	☐	☐	☐
I feel good most of the time…	☐	☐	☐	☐	☐
What I do in life is valuable and worthwhile…	☐	☐	☐	☐	☐
I can succeed if I put my mind to it…	☐	☐	☐	☐	☐
I am achieving most of my goals…	☐	☐	☐	☐	☐
In most activities I do, I feel energized	☐	☐	☐	☐	☐
There are people who appreciate me as a person…	☐	☐	☐	☐	☐
I feel a sense of belonging in my community…	☐	☐	☐	☐	☐

Please answer the following questions:			
How often do you feel that you lack companionship?	☐ Hardly Ever	☐ Some of the time	☐ Often
How often do you feel left out?	☐ Hardly Ever	☐ Some of the time	☐ Often
How often do you feel isolated from others?	☐ Hardly Ever	☐ Some of the time	☐ Often

HIPAA Release Agreement

<table>
<tr><td colspan="2">I hereby authorize CLUBHOUSE PROVIDER to release information concerning personal and/or medical history to Emergency Medical Personnel and fire protection.

Furthermore, I also understand that if I choose to participate in a clubhouse activity that occurs in the community, clubhouse staff will have a copy of my Emergency Fact Sheet with them, to provide any necessary information to the Emergency Medical Personnel. This information will be kept in a secure setting.</td></tr>
<tr><td>Recipient Full Name:</td><td>Click or tap here to enter text.</td></tr>
<tr><td>Signature:</td><td>Click or tap here to enter text.</td></tr>
<tr><td>Date:</td><td>Click or tap to enter a date.</td></tr>
</table>

Authorization for Release of Information

I hereby authorize The Iris Clubhouse to release protected information from my clinical record to/from the person / agency designated below:	
Organization:	
Director Name:	
Address:	
Phone Number:	
Fax Number:	
Designated Recipient Agency:	The Iris Clubhouse
I am requesting a release of the following specific information: **All relevant clinical data** for the following specific reasons: **Continuity of care**	
I agree to release relevant alcohol and drug information. **Initials:**	
THIS AUTHORIZATION AUTOMATICALLY EXPIRES ONE YEAR FROM DATE OF SIGNATURE. I understand that upon release and disclosure of the protected medical records and/or information, the records and information may be subject to re-disclosure by the Recipient and may no longer be protected by state or federal privacy regulations. I further understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the Iris Clubhouse address. No emails will be accepted. However, my revocation will not be effective to the extent that the Iris Clubhouse has already taken action in reliance on the authorization.	
Special Instructions/Alternative Expiration Date:	
Current/Former Recipient Name:	
Current/Former Recipient Signature:	
Date:	
Current/Former Recipient Address:	
Current/Former Recipient Phone Number:	

IRIS CLUBHOUSE

Iris Clubhouse Pledge of Confidentiality

Iris Clubhouse membership requires that all member and clubhouse records, (including obtaining oral or written knowledge of individual members' physical, mental and medical information obtained during membership interactions), are STRICTLY CONFIDENTIAL. This information is PROTECTED HEALTH INFORMATION under the federal and specific state laws and regulations governing the confidentiality of health records and CANNOT be disclosed without the members' express written consent unless otherwise provided for in the regulations.

A member also may revoke any previously given consent at any time except to the extent that action has been taken in reliance on it or after the occurrence of a specific ascertainable event or function.

I further agree to hold all member information, data and other health or medical information that are obtained within the context of my Iris Clubhouse membership and participation in the strictest confidence and will not disclose said information in accordance with this pledge. I also understand that unauthorized disclosure of members' PROTECTED HEALTH INFORMATION may jeopardize my ability to attend Clubhouse events and enjoy the benefits of full Iris Clubhouse membership.

I have read and understand the above information and agree to the confidentiality pledge.

______________________________________ ____________________

Signature Date

____

Print Name

Video and Photographic Release

I, (please print your name)____,
Give the Iris Clubhouse the absolute right and permission to use a photograph(s) and/or video(s) of me in its promotional materials and publicity efforts. I understand that the photographs may be used in a publication, print ad, direct-mail piece, electronic media (e.g. video, CD-ROM, Internet/WWW), or other form of promotion.

I release the Clubhouse, the photographer, their offices, employees, agents, and designees from liability for any violation of any personal or proprietary right I may have in connection with such use. I am 18 years of age or older.

Signature__________________________________Date__________________________

Print Name: ____

IRIS CLUBHOUSE

Signatures and Acknowledgment

I understand that by signing below, I agreed to abide by the rules and expectations of the Clubhouse. I understand that failure to abide by these rules will result in corrective action, including temporary expulsion from the Clubhouse. The Clubhouse is not a medical or psychiatric treatment facility and accepts no liability for your treatment. Members are expected to take responsibility for not consuming any food at the Clubhouse, which may trigger an allergic reaction.

____________________________________ __________________

Member Name, Print Date

____

Member Signature

_________________________________ ____________________________

Staff Name, Print Staff Signature