

CRYSTAL HOUSE CLUBHOUSE
 55 Lake Street, Suite 100
 Gardner, MA 01440
 Telephone: (978) 630-2794
 Fax: (978) 632-0367
 Email: crystalhouse@openskycs.org

Application/Referral

Date:		
Name:		
Address:		
Telephone: () -	Date of Birth: / /	
Email address:		
MassHealth Policy # (if applicable):		
Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/Masculine <input type="checkbox"/> Transgender Female/Feminine <input type="checkbox"/> Non-Binary/Gender Queer <input type="checkbox"/> Other: _____		
Language Preference:		
Race:		
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Black Hispanic	<input type="checkbox"/> Two or More Races
<input type="checkbox"/> Asian	<input type="checkbox"/> Pacific Islander/Hawaiian	<input type="checkbox"/> Chooses to not Identify
<input type="checkbox"/> Black or African American	<input type="checkbox"/> White Hispanic	<input type="checkbox"/> Unknown
	<input type="checkbox"/> White Non-Hispanic	
Ethnicity:		
Allergies:		
Highest Grade of School Completed:		
Need Areas (check all that apply):		
<input type="checkbox"/> Advocacy	<input type="checkbox"/> Benefits	<input type="checkbox"/> Support Group
<input type="checkbox"/> Housing	<input type="checkbox"/> Socialization	<input type="checkbox"/> Volunteer
<input type="checkbox"/> Wellness	<input type="checkbox"/> Vocational	<input type="checkbox"/> Other: _ _____
<input type="checkbox"/> Transportation	<input type="checkbox"/> Education	
DMH Adult Case Manager:	Telephone: () -	
Primary Care Physician:	Telephone: () -	
Psychiatrist:	Telephone: () -	
Therapist:	Telephone: () -	
Emergency Contact Name:	Relationship to Applicant:	
Address:		
Telephone: () -		

Member Consent

I, _____, have applied for lifetime membership at Crystal House Clubhouse and hereby authorize you _____ (Referral Source) to release any information to complete this application/referral form.

_____ (Applicant's Signature)

Referral Source:	Date:
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Name:	Title:	Agency:
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Address:

Telephone: () -

Reason for Referral:

Are there any Medical Concerns?

Are there any concerns and/or risk factors that Crystal House Clubhouse should know about this Applicant?

Diagnosis (list DSM-V diagnosis codes only):

Code	Description

Date of diagnosis or "Most recent" hospitalization:

Signature of Referral Source: