

# Goddard Riverside

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## TOP Clubhouse

### APPLICATION INFORMATION

To be considered for membership, the following must be submitted:

1. TOP Clubhouse membership application
2. Psychosocial or Psychiatric Evaluation
3. Copy of ID

If you have a question or need assistance in any way, please contact TOP Clubhouse at (212) 799-7171.

Applications can be submitted by:

**Email:** Frances Recibe at [frecibe@goddard.org](mailto:frecibe@goddard.org) and  
Tamar Mendelson at [tmendelson@goddard.org](mailto:tmendelson@goddard.org)

**Fax:** (646) 839-1276

**Mail:**

TOP Clubhouse  
Attn: Enrollment  
263 West 86th Street  
New York, NY 10024

# Goddard Riverside

## TOP Clubhouse

### MEMBERSHIP APPLICATION

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

A working community is at the heart of our model. By working together, members regain confidence, make friends, learn new skills, and make progress towards achieving their employment and educational goals. This opportunity to be a part of a successful working community is restorative and builds dignity and self-esteem.

To be eligible for membership an applicant must:

- Be interested in attending TOP Clubhouse, as membership is voluntary
- Have a mental illness diagnosis such as bipolar disorder, schizophrenia, schizoaffective disorder, or depression
- Be able to get to TOP Clubhouse
- Not pose a threat to our community
- Be at least 18 years of age
- Insurance is not required

TOP does not discriminate on the basis of race, color, religion, sex, age, national origin, veteran status, sexual orientation, gender identity, disability, or any other basis of discrimination prohibited by law.

*“The Clubhouse has control over its acceptance of new members. Membership is open to anyone with a history of mental illness, unless that person poses a significant and current threat to the general safety of the Clubhouse community.”*

*-Standard #2 for Clubhouse Programs, Clubhouse International*



## Prospective Member Information

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

*If you are not known by your legal name, please enter your preferred name below:*

\_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

### Gender Identity

<input type="checkbox"/> Woman	<input type="checkbox"/> Man
<input type="checkbox"/> Transgender Woman	<input type="checkbox"/> Transgender Man
<input type="checkbox"/> Other Gender	<input type="checkbox"/> Non-Binary

### Race and Ethnicity

<input type="checkbox"/> Alaskan Native/American Indian	<input type="checkbox"/> Asian
<input type="checkbox"/> Latino/Latina	<input type="checkbox"/> Black/African American (Non-Latino)
<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> White (Non-Latino)
<input type="checkbox"/> Mixed Race	<input type="checkbox"/> Other

### Sexual Orientation

<input type="checkbox"/> Heterosexual/Straight	<input type="checkbox"/> Bisexual
<input type="checkbox"/> Lesbian	<input type="checkbox"/> Gay
<input type="checkbox"/> Undisclosed	<input type="checkbox"/> Other Sexual Orientation

### Address

Street: \_\_\_\_\_ Apartment: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Landline Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Email: \_\_\_\_\_

### Housing Type (choose one):

<input type="checkbox"/> Own Home/Apartment (non-subsidized)	<input type="checkbox"/> Supportive Apartment
<input type="checkbox"/> Home of Family Member	<input type="checkbox"/> Nursing Home
<input type="checkbox"/> Single Room Occupancy (SRO)	<input type="checkbox"/> Shelter
<input type="checkbox"/> Supported Apartment (Subsidized)	<input type="checkbox"/> Homeless/Undomiciled
<input type="checkbox"/> 24 Hr. Supervised Housing	

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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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

What is your main goal in joining 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)

<input type="checkbox"/> SSI # _____ \$ _____ Start Date _____ Payee _____	
<input type="checkbox"/> SSDI # _____ \$ _____ Start Date _____ Payee _____	
<input type="checkbox"/> SNAP: \$ _____	<input type="checkbox"/> Public Assistance: \$ _____
<input type="checkbox"/> Veteran Benefits: \$ _____	<input type="checkbox"/> Retirement Benefits: \$ _____

### **Medical Insurance**

(Not necessary for membership)

Please provide Insurer name and policy number if you have insurance.

<input type="checkbox"/> Straight Medicaid Provider: _____ ID # _____ Effective Date: _____
<input type="checkbox"/> Medicare Provider: _____ ID # _____ Effective Date: _____
<input type="checkbox"/> Private Provider: _____ ID # _____ Effective Date: _____
<b>If Medicaid Managed Care, please include name of managed care company:</b>

### **Education**

(Please check highest academic level)

<input type="checkbox"/> None	<input type="checkbox"/> Some High School	<input type="checkbox"/> GED/TASC
<input type="checkbox"/> High School Diploma	<input type="checkbox"/> Trade School	<input type="checkbox"/> Some College
<input type="checkbox"/> Associate's Degree	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Some Graduate Work
<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Advanced Graduate Degree	

### **Employment History**

Are you currently employed?  YES  NO

If NO, have you worked in the last 12 months?  YES  NO

If NO, have you ever worked for pay?  YES  NO

## Medical and Health Conditions

(Check all that apply)

<input type="checkbox"/> Mobility Impairment	<input type="checkbox"/> Severe Allergic Reactions
<input type="checkbox"/> Asthma	<input type="checkbox"/> New Psychiatric Medication
<input type="checkbox"/> Blind/Visual Impairment	<input type="checkbox"/> Deaf/Hearing Impairment
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Epilepsy/Seizure Disorder	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Other: _____	

## Medical & Psychiatric Contacts

**Psychiatrist:** \_\_\_\_\_

Agency: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

How long have you been seeing this psychiatrist? \_\_\_\_\_ years \_\_\_\_\_ months

**Primary Care Doctor:** \_\_\_\_\_

Agency: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

How long have you been seeing this medical doctor? \_\_\_\_\_ years \_\_\_\_\_ months

**Therapist:** \_\_\_\_\_

Agency: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

How long have you been seeing this Therapist? \_\_\_\_\_ years \_\_\_\_\_ months

## Emergency Contact

**Full name:** \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_

## Psychiatric Diagnosis (DSM V):

Schizophrenia    Schizoaffective    Major Depressive Disorder    Bipolar

Other: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

## Medications

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

Name: _____ Dosage: _____ Strength: _____ Freq: _____ Start Date: _____
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## Substance Use History

Do you currently smoke tobacco or use tobacco products?

YES  NO

Do you have a history of smoking or using tobacco products?

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

Do you have a history of alcohol or drug abuse? Your answers will not influence your application decision.

**Alcohol**  YES  NO If YES, in the past 12 months?  YES  NO

**Drugs**  YES  NO If YES, in the past 12 months?  YES  NO

## Legal History

Please answer all questions

Have you ever been in jail?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been in prison?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been convicted of a misdemeanor?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been convicted of a felony?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever physically injured another person?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have any history of violent behavior?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Have any of the above occurred in the past 12 months?  YES  NO

Please explain any Legal History:

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

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

<b>Please indicate your agreement or disagreement with the following statements:</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neither</b>	<b>Agree</b>	<b>Strongly Agree</b>
My life has a clear sense of purpose...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am optimistic about my future...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel good most of the time...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What I do in life is valuable and worthwhile...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can succeed if I put my mind to it...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am achieving most of my goals...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In most activities I do, I feel energized...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are people who appreciate me as a person...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel a sense of belonging in my community...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>PLEASE answer the following questions:</b>				
How often do you feel that you lack companionship	<input type="checkbox"/> Hardly Ever	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Mostly	<input type="checkbox"/> Completely
How often do you feel left out?	<input type="checkbox"/> Hardly Ever	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Mostly	<input type="checkbox"/> Completely
How often do you feel isolated from others?	<input type="checkbox"/> Hardly Ever	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Mostly	<input type="checkbox"/> Completely



## Signatures and Acknowledgements

It is very important that all components of this application are absolutely complete. Any missing or incomplete components will, unfortunately, delay the application process. In addition, it is helpful to include all documents at the same time.

Clubhouse operations track and manage data on member utilization of services. Member data and utilization data is used for program evaluation, quality assurance, reimbursement, reporting, and research. Operational data on members and service utilization is deidentified, anonymous, and reported in the aggregate when used for the purpose of external research and projects.

By signing below the prospective member or referrer is attesting to the accuracy of the information contained in this application and acknowledging Clubhouse practices.

\_\_\_\_\_ Date: \_\_\_\_\_  
*Prospective Member Signature*

\_\_\_\_\_ Date: \_\_\_\_\_  
*Referral Source Signature (if applicable)*

Check if referral from Clubhouse Enrollment Center (for applicant review team only).