



PO Box 864301  
Plano, TX 75086

PRELUDE CLUBHOUSE MEMBERSHIP APPLICATION  
(Please carefully read and print all answers. All blank spaces must be filled.)

**Personal Information:**

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_ Clubhouse #: \_\_\_\_\_ (to be filled in by staff)

Name: First: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

**1. Referral Type**

- Self, Family, Friends       Private Practitioner (Psychiatrist/MD)       Community Mental Health Center  
 Green Oaks/Local Hospital       Another Clubhouse       State Social Services       County Social Services  
 Voc Rehab/DARS       Homeless Shelter       Mental Health Court       Other: \_\_\_\_\_

**2. Referring Agency:** \_\_\_\_\_

**Applicant's Mailing Address:** \_\_\_\_\_

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

**Applicant's Permanent Address:** \_\_\_\_\_

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

**Primary phone:** (    ) \_\_\_\_\_ **Alternate phone:** (    ) \_\_\_\_\_

**3. Housing Type:**

- Own Home/Apartment (Non-subsidized)       Home of a family member (shared responsibility)       Home of a friend  
 Home of a family member (dependent on family)       Temporary Housing       Supported apartment  
 Supervised housing       Group home       Nursing Home       Assisted Living Facility       Prison/Jail       Homeless  
 Other (please specify): \_\_\_\_\_

**4. Housing Status:**

- Alone       With Roommate(s)/Housemate(s)       With Parent(s)       With Other Adult Relative(s)  
 With minor children       With Partner       With Partner and Child(ren)       Institutional setting

**5. Housing Satisfaction:**

- Very Satisfied       Somewhat Satisfied       Neutral       Somewhat Unsatisfied       Very Unsatisfied

**6. Social Interaction:**

- Do you have a close friend you can talk to?  Yes  No
- Do you have frequent conflicts with friends (more than once per month)?  Yes  No
- Are you satisfied with your family relationships?  Yes  No
- Do you have conflicts with your family members (more than once per month)?  Yes  No
- Do you feel isolated?  Yes  No
- 

- 1. Gender:**  Male  Female  Other (please specify): \_\_\_\_\_
- 2. Ethnicity:**  African American  American Indian/Native American  Asian  Caribbean  Caucasian  
 Latino/Hispanic  Middle Eastern  Pacific Islander  Prefer not to say
- 3. Language:**  English  Primary Other (please specify): \_\_\_\_\_
- 4. Marital Status:**  Single/Never Married  Widowed  Permanent Partner  Divorced  Separated  Married
- 5. Number of Minor Children:** \_\_\_\_\_
- 6. Primary Weekday Activity:**  Independent Employment  Clubhouse Work  Parenting/Care Taking at Home  
 Other Volunteer Work  School/High School  School/Trade School/College  Sheltered Workshop  
 Day Program Outside of the Clubhouse  Transitional Employment  No Structured Daytime Activity
- 7. Primary Reasons for wanting to attend Prelude Clubhouse:** \_\_\_\_\_
- 8. Education Level:**  Less than High School  GED  High School Diploma  Trade School/Vo-Tech  
 Some College  Associate's Degree  Bachelor's Degree  Some Graduate Work  Master's Degree  
 Advanced Graduate Work/Degree: \_\_\_\_\_
- 9. Do you have outstanding student loans?** \_\_\_\_\_
- 10. Are you interested in continuing your formal education?** \_\_\_\_\_
- 

**1. Current Employment:**

- Full Time (32 hours per week or more)
- Part Time (Less than 32 hours per week)
- Day Labor (Selected to work each day at employment agency)
- Contract Labor (Selected to work on jobs or projects for a limited period of time)
- No job at this time and I am looking for employment
- No job at this time and I am not looking

**2. Job held the longest:** \_\_\_\_\_

**3. Income Source(s) – Type of Income:**

- |  |  |
|--|--|
| <input type="checkbox"/> Wages - Independent Employment  | <input type="checkbox"/> Local Assistance (County/State) |
| <input type="checkbox"/> Wages – Transitional Employment | <input type="checkbox"/> AFDC                            |
| <input type="checkbox"/> Wages – Supported employment    | <input type="checkbox"/> Veteran’s Benefits              |
| <input type="checkbox"/> Wages – Sheltered Workshop      | <input type="checkbox"/> Retirement Benefits             |
| <input type="checkbox"/> SSDI                            | <input type="checkbox"/> Family’s Support                |
| <input type="checkbox"/> SSI                             | <input type="checkbox"/> Friend’s Support                |
| <input type="checkbox"/> General Assistance (State)      | <input type="checkbox"/> No Financial Support            |
| <input type="checkbox"/> Other (please specify): _____   |  |

**4. Total Amount of Monthly Income:** \_\_\_\_\_

**5. What type of work would you like to do?** \_\_\_\_\_

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**Medical Alerts – Check all that apply:**

- |  |  |  |                                       |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Chronic Physical Illness                          | <input type="checkbox"/> Severe Allergic Reactions | <input type="checkbox"/> Recent Surgery    |                                       |
| <input type="checkbox"/> Deaf/Hearing Impairment                           | <input type="checkbox"/> Blind/Vision Impairment   | <input type="checkbox"/> Epilepsy/Seizures |                                       |
| <input type="checkbox"/> Sleep Apnea                                       | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Other Physical Disability: (please specify) _____ |  |  |                                       |
- 

**1. Emergency Contact Information:**

Name: \_\_\_\_\_  
Relationship to Applicant: \_\_\_\_\_  
Telephone: \_\_\_\_\_

**2. Treatment Provider:**

Name: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Release? (Y/N): \_\_\_\_\_

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**1. Have you ever been convicted of a misdemeanor?**  Yes  No

**2. Have you ever been convicted of a felony?**  Yes  No

**Please explain:** \_\_\_\_\_

**3. Do you have a history of violent behavior toward others?**  Yes  No

**Please explain:** \_\_\_\_\_

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**1. Medical Insurance Policy(s): Check all types that apply.**

- Medicaid             Medicare             Medicare-Managed Care             Veteran's Benefits
- Private Insurance     NTBHA             LifePath             Worker's Compensation             Self-pay (no insurance)
- Other (please specify): \_\_\_\_\_

**2. Last Medical Exam:** MM/DD/YYYY \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**3. Last Dental Exam:** MM/DD/YYYY \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**4. Nutrition:** Number of meals per day \_\_\_\_\_            Special dietary needs: \_\_\_\_\_

**5. Exercise:**  30 min/day             30 min/week             30 min 3 times/week             I do not exercise

**6. Do you currently take prescribed medications or over the counter medications,**  Yes             No

**Natural remedies or vitamins and minerals?**             Yes             No

**Other** (please specify): \_\_\_\_\_

**7. Are you taking your medications as prescribed?**             Yes             No

**8. If you are female, are you currently pregnant?**             Yes             No

**9. Psychiatric History:**

Total Number of Hospital Admissions: \_\_\_\_\_

Estimate Total Months of ALL Hospitalizations: \_\_\_\_\_

Length (months) of LONGEST Hospitalization: \_\_\_\_\_

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**1. Transportation Issues:**

Can you provide your own transportation to and from Prelude Clubhouse?             Yes             No

Will you need to use public transit to get to Prelude Clubhouse and back home?             Yes             No

Will you need to ride with other members to get to the Clubhouse and back home?             Yes             No

Will transportation be a problem if you secure Transitional Employment beyond walking distance of the Clubhouse?             Yes             No

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**To the best of my knowledge, the above information is complete and accurate.**

**Signature of Applicant:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*The mission of Prelude Clubhouse is to provide an intentional environment where adults living with mental illness have opportunities to be productive, develop social connections, obtain employment, and achieve recovery. While we strive to support and assist each member in attaining their personal goals, we cannot predict or guarantee outcomes for individuals.*



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469-301-6639

**PAGES 5 & 6 TO BE FILLED OUT BY A TREATMENT PROVIDER**

I understand that my records are protected under Federal Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I, \_\_\_\_\_ authorize \_\_\_\_\_,  
(Prospective Prelude Clubhouse Member) (My Psychiatric Treatment Provider)

my treatment provider, to fill out this Assessment so that I may be considered for Membership at Prelude Clubhouse.

Prospective Member's Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Prospective Member's Signature \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Dear Treatment Provider:**

**Per Clubhouse International Standards, in order to apply for Clubhouse Membership, a prospective Member must be 18 years old or more, have a diagnosed serious mental illness (as shown in #1 below), and be deemed to be safe for the physical and emotional environment of the other Clubhouse Members and staff. With that in mind, please answer the following questions to the best of your knowledge:**

**1. Primary Diagnosis:**

- Schizophrenia                       Bi-Polar Disorder                       Major Depression  
 Schizoaffective Disorder                       Other Psychotic Disorder                       Other Serious Mental Illness

If other was selected, please specify: \_\_\_\_\_

**2. How long have you known the applicant?** \_\_\_\_\_

**3. History with Alcohol:**

- Has applicant had a problem with alcohol?                       Yes                       No  
Has applicant been in treatment for an alcohol problem?                       Yes                       No

**TREATMENT PROVIDER ASSESSMENT -- CONTINUED**

(#3 Continued)

Is applicant currently in treatment or in a support group?  Yes  No

Does (s)he want help with an alcohol problem?  Yes  No

How long has (s)he been clean and sober? \_\_\_\_\_

**4. History with Drugs:**

Has applicant had a problem with drugs?  Yes  No

Has applicant been in treatment for a drug problem?  Yes  No

Is applicant currently in treatment or in a support group?  Yes  No

Does (s)he want help with a drug problem?  Yes  No

How long has (s)he been clean and sober? \_\_\_\_\_

**5. Drug/Alcohol Notes (Include Type of Drug, Amount, Frequency):** \_\_\_\_\_

**6. History of Violence**

**Are you aware of any violent behaviors that the applicant exhibits or know of any violent or criminal incidents in which (s)he has been involved?**

Yes  No

If yes, please describe: \_\_\_\_\_

**In your opinion, is the candidate for membership likely to become a danger to him/her self or others?**

Yes  No

**7. Referral Source:**

Name and credentials: \_\_\_\_\_

Referring Agency: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Return Form to:

Prelude Clubhouse  
PO Box 864301  
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