



A Mental Health Recovery Program  
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[www.capitalclubhouseinc.org](http://www.capitalclubhouseinc.org)

Confidential email: [amuhlbach@capitalclubhouseinc.org](mailto:amuhlbach@capitalclubhouseinc.org)

Please have this referral completed by a licensed treating mental health professional who knows the prospective member. We also require a current Diagnostic Assessment. The completed form can be emailed to the above email address using "Encrypt" in the subject line or other form of protection. After receipt of the completed referral, the new member will be contacted about attending an orientation/information session.

**To be completed by a professional who has access to individual's psychiatric records:**

REFERRED INDIVIDUAL'S NAME: \_\_\_\_\_

Address \_\_\_\_\_

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

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**REFERRAL SOURCE DATA**

How long known: \_\_\_\_\_

Name: \_\_\_\_\_ Agency: \_\_\_\_\_

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

Phone: \_\_\_\_\_

REASON FOR REFERRAL: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please provide us with additional information about this person that will assist in their recovery process:

\_\_\_\_\_

**PLEASE NOTE: Clubhouse services are not appropriate for individuals who exhibit any of the following:**

- Behaviors which threaten and/or pose a current health and safety risk to themselves or others
- Behaviors that disrupt the daily work of the Clubhouse
- Behaviors that require excessive redirection and/or monitoring
- A severity of symptoms requiring a more intensive level of treatment

My client does not exhibit any of the above behaviors/needs. Initial Here \_\_\_\_\_

Do you feel that your client can engage in a Clubhouse whose policies include: zero tolerance for drugs and alcohol on the premises, non-violence, appropriate communication, and respect for others?  Yes  Not at this time

PROSPECTIVE MEMBER INFORMATION

Income Source: \_\_\_\_\_ Monthly amount: \_\_\_\_\_  
How Member will get to/from Clubhouse: \_\_\_\_\_ Approximate Transportation Cost: \_\_\_\_\_  
Primary Insurance: \_\_\_\_\_ Receive DC Medicaid? \_\_ YES \_\_ NO  
DC Medicaid Number: \_\_\_\_\_

Member's Psychiatrist/Mental Health Prescribing Practitioner:  
\_\_\_\_\_

Agency: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Member's Core Service Agency: \_\_\_\_\_  
CSA Point of Contact: Name: \_\_\_\_\_ Phone/Email: \_\_\_\_\_  
Level of Community Support receiving and from where: \_\_\_\_\_  
If in ACT, please list expected date/plan of step down to Community Support: \_\_\_\_\_  
\_\_\_\_\_

Member's Primary Care Provider: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Address \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Psychiatric Diagnosis \_\_\_\_\_  
Secondary Psychiatric Diagnosis including any SUD \_\_\_\_\_  
\_\_\_\_\_

Other Diagnoses \_\_\_\_\_  
\_\_\_\_\_

Substance Abuse History  
\_\_\_\_\_  
\_\_\_\_\_

Is prospective member in recovery? \_\_\_\_\_  
Current Mental Health Treatment Receiving (if any): \_\_\_\_\_  
Current Medications: \_\_\_\_\_

Allergies/Other Medical/Physical Issues or Communication Issues That May Affect Member's Participation  
In the Program? \_\_ YES \_\_ NO Please Explain:  
\_\_\_\_\_  
\_\_\_\_\_

Person Completing this Form: \_\_\_\_\_ Phone: \_\_\_\_\_

*By signing below, I certify that all information on this form is true and correct to the best of my knowledge.*

Signature of licensed mental health professional: \_\_\_\_\_  
Print Name \_\_\_\_\_ Date \_\_\_\_\_



**CONFIDENTIAL**

Prospective Member Applicant

Release of Information Form

I hereby give consent for the release of pertinent medical, hospital and psychological information from medical and/or mental health professionals associated with my care with (provider:)

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for completion of appropriate referral information for my application for membership to the Capital Clubhouse. I also understand that if I am to become a member of Capital Clubhouse that **my Goal/Treatment Plan/Plan of Care will be updated to reflect that**. I understand that any information released to the Capital Clubhouse is confidential and will be remain confidential by the Capital Clubhouse.

Name of Prospective Member: \_\_\_\_\_

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

Received By: \_\_\_\_\_ Date: \_\_\_\_\_