MILESTONE
CLUBHOUSE

Dear Prospective Member:

Thank you for your interest in becoming a member of Milestone Clubhouse. This is the application packet that must be completed.

- **Application for Services:** Prospective member completes

AND EITHER OF THE FOLLOWING:

- **Milestone Eligibility Determination Form** completed by your Psychiatrist or Therapist or Family Doctor

OR

- **Adult SPMI/PRS Eligibility Determination KS form** provided by your Community Mental Health Center

Please return the application packet to **Katie Gibbons**

Fax: (316) 269-3550 or by Email at: katie.gibbons@breakthroughwichita.org

Address: 206 N Main St., Hutchinson, Ks 67501

Once we have received the Application for Services and one of the Eligibility Determination forms, we will assess your eligibility for membership. If you are eligible, we will call to set up a time for enrollment.

If you are not eligible, we will mail a letter explaining why. If your address or phone number changes, please let us know so we can maintain contact with you.

If you have any questions, please call Katie Gibbons at 620-888-5003

MILESTONE CLUBHOUSE

Application for Services

Name:_____

FIRST LAST MI MAIDEN (if applicable)

Address:_____ **City:** _____

Zip Code:_____ **Home Phone**: (____) _____

Cell Phone: (_____) _____ **Email:** _____

Age:_____ **Date of Birth**:_____

Race: _____ **Marital Status:** _____ **Gender:** ☐**Male** ☐**Female** ☐**Non-Binary**

Do you get (Circle all that apply): Medicaid Medicare MediKan Income _____

REFERRAL SOURCE (Circle one): ☐**Alcohol/Drug Program** ☐**Family/Friend** ☐**VA**

☐ **Horizons** ☐**Facebook/Twitter** ☐**Private Doctor/Therapist** ☐**Milestone Clubhouse Website**

☐**Self** ☐**Other**_____

Referral Name:_____ **Phone:** (___) _____

Address:_____ **Zip Code:**_____

EMERGENCY CONTACT INFORMATION

Legal Guardian:_____ **Relationship:** _____ **N/A:**_____

Address:_____ **City:** _____

Zip Code:_____ **Phone**: (____) _____

Cell Phone:_____ **Email:** _____

Emergency Contact/Relative:_____ **Relationship**_____

Address:_____ **City:** _____

Zip Code: _____ **Phone:** (___)_____

Cell Phone:_____ **Email:** _____

Case manager? Yes No Name :_____

Agency: _____ **Phone**:_____

Cell phone:_____ **Email:** _____

EDUCATION

Degree or Last Grade Completed _____

Are you in any type of educational classes? _____

EMPLOYMENT

Are you currently working/where? _____

If not, date last employed. _____

MENTAL HEALTH

List any medications: _____

Psychiatrist/Agency: _____ **Phone**:_____

Therapist/Agency: _____ **Phone:** _____

Where were you last hospitalized? _____ **When:** _____

LEGAL

Do you have a payee/ conservator? If so, who? _____

Any legal problems or past convictions? Yes No If Yes, please explain:

_____

Probation/Parole Officer:_____ **Phone**:_____

MEDICAL/PHYSICAL HEALTH (different from Mental Health)

List any medical/physical health problems: _____

List any medications: _____

Physician: _____ **Phone**:_____

DRUG/ALCOHOL TREATMENT

List alcohol or drugs used: _____

If discontinued, date of last use: _____

Have you ever been in treatment? Yes No Was it inpatient? Yes No

If Yes, where and when? _____

REASON FOR REFERRAL

What support services are you interested in?

☐ **Employment** ☐ **Evening/Weekend Social Activities** ☐ **Wellness/Physical health**

☐ **Education** ☐ **Advocacy/Presentations** ☐ **Housing**

_____ _____

Applicant Signature **Date**

_____

Person (If not Self) Completing Form

MILESTONE CLUBHOUSE

Phone: (620) 888-5003 206 N. Main Hutchinson, KS 67501 Fax: (316) 269-3550

Dear Prospective Member:

This is the part of the application process that your Psychiatrist or Therapist or Family Doctor needs to complete and return to us.

- Milestone Eligibility Determination Form (Attached)

OR

- Adult SPMI/PRS Eligibility Determination KS Form (Provided by the Community Mental Health Center)

If you have any questions, please call Katie Gibbons at (620) 888-5003.

Milestone Clubhouse
Eligibility Determination Form
(to be completed by Psychiatrist, Therapist, or Family Doctor)

Consumer Name _____

Address _____ Zip Code _____

Phone _____ DOB _____ Social Security # _____

DSM-5 code and Diagnosis:

_____ _____
Code

_____ _____
Code

_____ _____
Code

_____ _____
Code

_____

_____

1. ☐Yes ☐No Borderline Intellectual Functioning

2. ☐Yes ☐No Mental Retardation

3. ☐Yes ☐No Traumatic Brain Injury

If yes to #1, #2, or #3 what level of functioning: ☐Needs 1:1 support ☐Unable to tolerate noise/activity/commotion ☐Anger outbursts in response to environment or interactions w/ others ☐Does well in groups w/ minimal supervision ☐Other: _____

4. Please review each of the following and check any that apply.

☐History of violent behavior, ☐person felony conviction, ☐arrested for physical violence toward others,
☐ verbal harassment of others, ☐anger outbursts, ☐destruction of property, ☐stalking behavior
☐ Other: _____
☐ None

_____ _____
Name of Physician/Therapist (please print) Date

_____ _____
Agency/Office Name Phone