

# RAILWAY CLUBHOUSE

1016 Grandview Ave. Newton, KS 67114  
FAX: (316) 269-3550 Phone: (316) 333-8198

Dear Provider

It is our intention to create an inviting, positive, and safe environment focused on supporting those who live with severe mental illness. We ask that you provide limited information to help us towards that goal.

The attached form needs to be completed by the applicant's Psychiatrist, Therapist or Family Doctor to determine eligibility for membership to the Railway Clubhouse. Once we receive the completed form, we will notify the applicant.

- Railway Clubhouse Eligibility Determination Form (Attached)

Please return the Eligibility Determination Form to **David Kapten**:

at

**Fax: (316) 269-3550**

or

**Mailing address:** P.O. Box 670, Wichita, Ks 67201

If you have any questions, please contact David Kapten at:

Phone (316) 333-8198

Or

Email: **david.kapten@railwayclubhouse.org**

**Railway Clubhouse FAX: (316) 269-3550 Phone: (316) 333-8198**  
**Eligibility Determination Form**  
**(to be completed by Psychiatrist, Therapist, or Family Doctor)**

Applicant 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 Developmental Disability
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 Psychiatrist/Therapist (please print)

\_\_\_\_\_  
Agency/Office Name

\_\_\_\_\_  
Name of Psychiatrist/Therapist (signature)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant or Legal Guardian (if applicable)

\_\_\_\_\_  
Date

# RAILWAY CLUBHOUSE

1016 Grandview, Newton, KS 67114  
FAX: (316) 269-3550 Phone: (316) 333-8198

Dear Prospective Member:

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

Prospective member completes:

**Application for Membership**

Psychiatrist or Therapist or Family Doctor completes:

**Railway Clubhouse Eligibility Determination Form**

Please return the application to **David Kapten**:

at

david.kapten@railwayclubhouse.org

or

**Fax: (316) 269-3550**

or

**Mailing address:** P.O. Box 670, Wichita, Ks 67201

Once we have received the Application for Services and the Eligibility Determination form, 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 David Kapten at (316) 333-8198.

# RAILWAY CLUBHOUSE

## Application for Membership

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

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

Prairie View  Facebook/Twitter  Private Doctor/Therapist  Breakthrough Website

Self  Other \_\_\_\_\_

Referral Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Emergency Contact/Relative: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

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

Case manager? Yes No Name: \_\_\_\_\_

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

Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_ N/A: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

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

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Person (If not Self) Completing Form

\_\_\_\_\_  
Date



### Railway Clubhouse

1016 Grandview Ave Newton KS 68114 (316) 333-8189

Authorization for use and disclosure of protected health information.

_____	_____	_____
Member Last Name	Member First Name	Date of Birth
_____	_____	_____
Address	City, State, Zip	Phone #

I, the member or legal representative, hereby authorize Railway Clubhouse to:

RELEASE the following information:

- \*Information relevant to an emergency situation
- \*Verbal progress updates/reviews
- \*Appointments, Scheduling, Attendance
- \*Treatment Plan(s)
- \*Substance use appointment/scheduling/attendance
- \*Substance use progress review/summary
- \*Discharge Summary
- \*Education Reports
- \*Legal Documents/Reports

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

OBTAIN the following information:

- \*Information relevant to an emergency situation
- \*Verbal progress updates/reviews
- \*Appointments, Scheduling, Attendance
- \*Treatment Plan(s)
- \*Substance use appointments/scheduling/attendance
- \*Substance use progress review/summary
- \*Discharge Summary
- \*Education Reports
- \*Legal Documents/Reports

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

**TO/FROM: Name/Agency**  
\_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Restrictions: (The information indicated will be disclosed unless there are specific restrictions noted here):

Verbal Only      Other: \_\_\_\_\_

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Railway Clubhouse

1016 Grandview Ave Newton KS 68114 (316) 333-8189

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- I understand that under state and federal confidentiality provisions, only the information specified can be released to the specified person or agency (CFR42 part 2; KAR 30-6—47(b)(5))
- I understand that Railway Clubhouse cannot ensure the recipient will maintain confidentiality of the information I have authorized to be released.
- I understand this authorization will be honored unless revoked verbally or in writing. Revocation may be made at any time except to the extent the action has already been taken. To revoke an authorization, I need to notify Railway Clubhouse.
- I understand that if the person or organization authorized to receive this information is not a healthcare provider or health plan or is not otherwise covered under federal privacy regulations, the released information may be re-disclosed and will no longer be protected by federal privacy laws. I understand that certain persons or organizations may not re-disclose substance abuse treatment information.
- I understand the records may include medical, psychiatric treatment, substance use (alcohol/drug) and/or HIV (AIDS) information.
- I understand if I use a general designation regarding to whom my information may be disclosed, I have a right to receive a list of the entities the information was disclosed to.
- I understand this authorization is voluntary and I verify I have been given the chance to ask and receive answers to questions. I understand my services will not be conditioned upon signing this authorization.

I understand that unless I revoke it earlier, this authorization will automatically expire one year from the date of signature unless otherwise specified (specific date or event may not exceed one year).

Specific date or event: \_\_\_\_\_

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\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Representative Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Member

This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit the recipient from making any further disclosure of it without the specific written consent of the person to whom it pertains or except as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.