



1111 W. South Street

Salina, KS 67401

785-515-2136

RESILIENCE CLUBHOUSE

Application for Membership

Dear Prospective Member:

We appreciate your interest in becoming a member of the new Resilience Clubhouse. Please complete and submit the following documents:

- **Application for Services: Prospective member completes**
- **Resilience Clubhouse Eligibility Determination Form completed by your Psychiatrist, Therapist, Physician, or Case Manager.**

Please return the application packet to Claudette Humphrey, Program Director

- **Fax: (316) 269-3550**
- **Email: claudette.humphrey@resilienceclubhouse.org**
- **In Person or By Mail**
1111 W. South St., Salina, KS 67401

Once we receive the completed Application for Services and Eligibility Determination form, we will assess your membership eligibility. If you are eligible, we will call to set up a time for enrollment.

If the application is determined to be ineligible, we will mail a letter explaining why. If your address or phone number changes, please let us know so we can keep in touch.

If you have questions or concerns or need assistance with the application, please contact Claudette Humphrey or Micah Crosley:

- **Office: 785-515-2136**
- **Cell Phone: 785-342-5964**
- **claudette.humphrey@resilienceclubhouse.org**
- **micah.crosley@resilienceclubhouse.org**

Please complete this application in its entirety. An incomplete application may delay processing.



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FIRST MIDDLE LAST SUFFIX (If applicable)

Physical Address, City, and Zip Code

Home Phone:

Cell Phone:

Email:

Age:

Date of Birth:

Ethnicity: Hispanic

Non-Hispanic

Race: White African-American Native American Pacific Islander

Asian Two or more races Other _____

Marital

Status: Single Married Divorced Other

Gender: Male Female Non-Binary Other

Employed? YES NO If YES, where? FT PT

Hours Worked: Day Shift Night Shift Overnight Shift

Other Source of Income: Disability Social Security Retirement None

REFERRAL SOURCE: CKF CKMHC Ashby House Family/Friend

V.A. Self-Referral Salina Grace Salina Rescue Mission

Legal Referral Case Manager CAPS Personal Doctor

Counselor/Therapist Website Social Media Current Member

Other

Referral Name:

Address:



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City and Zip Code:

Phone:

EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Address:

City:

Zip Code:

Phone:

Email:

Case manager? YES NO

Name:

Agency:

Phone:

Cell phone:

Email:

MENTAL HEALTH

List any medications:

Psychiatrist/Agency:

Phone:

Therapist/Agency:

Phone:

Date of Last Hospitalization?

Where:

LEGAL

Do you have a payee/conservator? YES NO

If yes, provide name:

Any legal issues or past convictions? YES NO

If Yes, please explain:

Probation/Parole Officer:

Phone:



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MEDICAL/PHYSICAL HEALTH (different from Mental Health)

List any medical/physical health problems:

List any medications:

Medical Physician:

Phone:

Are you covered by any of the following health benefits:

Health Insurance

KanCare (Medicaid)

Medicare

None

REASON FOR REFERRAL

What supports are you interested in?

Employment

Evening/Weekend Socials

Wellness/Physical health

Education

Advocacy/Presentations

Housing

Applicant Signature:

Date:

Person Completing Form (If other than the applicant):