CRYSTAL HOUSE CLUBHOUSE
55 Lake Street, Suite 100
Gardner, MA 01440
Telephone: (978) 630-2794
Fax: (978) 632-0367
Email: crystalhouse@openskycs.org

Application/Referral

Date:	
Name:	
Address:	
Telephone: ( ) -	**Date of Birth: / /**
Email address:	
MassHealth Policy # *(if applicable):*	
Gender Identity: ☐ **Male** ☐ **Female** ☐ **Transgender Male/Masculine** ☐ **Transgender Female/Feminine** ☐ **Non-Binary/Gender Queer** ☐ **Other:** ______________________________	
Social Security Number(optional):	**Language Preference:**

Race:		
☐ **American Indian/Alaskan Native**	☐ **Black Hispanic**	☐ **Two or More Races**
☐ **Asian**	☐ **Pacific Islander/Hawaiian**	☐ **Chooses to not Identify**
☐ **Black or African American**	☐ **White Hispanic**	☐ **Unknown**
	☐ **White Non-Hispanic**	

Ethnicity:
Allergies:
Highest Grade of School Completed:

Need Areas (check all that apply):		
☐ **Advocacy**	☐ **Benefits**	☐ **Support Group**
☐ **Housing**	☐ **Socialization**	☐ **Volunteer**
☐ **Wellness**	☐ **Vocational**	☐ **Other:** _ __________
☐ **Transportation**	☐ **Education**	

DMH Adult Case Manager:	**Telephone: ( ) -**
Primary Care Physician:	**Telephone: ( ) -**
Psychiatrist:	**Telephone: ( ) -**
Therapist:	**Telephone: ( ) -**
Emergency Contact Name:	**Relationship to Applicant:**
Address:	
Telephone: ( ) -	

Member Consent		
I, _________ ____________________________, have applied for lifetime membership at Crystal House Clubhouse and hereby authorize you______ ___________________________ (Referral Source) to release any information to complete this application/referral form. **___________________________________ (Applicant's Signature)**		
Referral Source:	**Date:**	
Name:	**Title:**	**Agency:**
Address:		
Telephone: ( ) -		
Reason for Referral:		
Are there any Medical Concerns?		
Are there any concerns and/or risk factors that Crystal House Clubhouse should know about this Applicant?		
Diagnosis (list DSM-V diagnosis codes only):		

Code	**Description**

Date of diagnosis or "Most recent" hospitalization:
Signature of Referral Source: