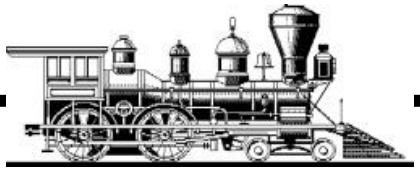
Union Station Clubhouse



100 Corporate Crossing Road, Uniontown, PA 15401
Phone: (724) 439-9311 Fax: (724) 439-9334
Web: www.unionstationclubhouse.com

Dear Referrer or Referring Agency:

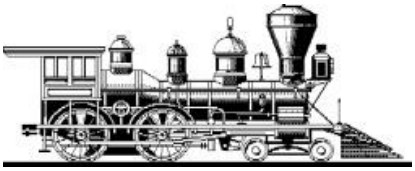
Due to the adoption of Pennsylvania Department of Public Welfare regulations. In addition to the previously required items, a NEW member will also need the following for admission to the Union Station Clubhouse:

- The most CURRENT Psychiatric Evaluation from a Mental Health Professional
- The attached recommendation form, signed from a Licensed Practitioner of the Healing Arts (LPHA) stating the member's diagnoses as well as what they recommend which goals the member would like to pursue while attending Union Station Clubhouse.
    - The form can only be signed by one of the following:
        - Medical Doctor, Psychiatrist (M.D., D.O.)
        - Physician's Assistant (PA, PA-C)
        - Certified Registered Nurse Practitioner (CRNP)
        - Psychologist (Psy. D., Psy. ABD)
    - Additionally, as of January 1, 2018, the LPHA will be REQUIRED to list their PROMISEe number as well as their NPI number in order for the member to attend the program.
- As always, a new admission to the Union Station Clubhouse program will also require copies of the following information:
    - Medical Insurance Cards
    - Social Security Card
    - Driver's License / Photo ID – Current and Valid.

If you have any questions, please do not hesitate to contact our staff at (724) 439-9311, we will try to assist you in any way that we possibly can.

Union Station Clubhouse Staff

Union Station Clubhouse Referral Form



Person Making Referral:
_____

Referring Agency: _____ Phone: _____
Agency: _____ Date of Referral: _____

Member Demographics

Individual Name: _____

Address: _____

City: _____ ZIP Code: _____

Contact Phone: _____ Age: _____

Date of Birth: _____ Medicaid ID #: _____

Social Security #: _____ Race/Ethnicity: _____

General Reason for Referral: _____
Check one: ____ Living ____ learning ____ working _____Socializing

Mental Health Information

Diagnosis Information

Axis	ICD9 Code	Clinical Name
I	*F* _____.____	_____
II	*F* _____.____	_____
III	*F* _____.____	_____
IV	*F* _____.____	_____
V	*F* _____.____	_____

Treatment Information

Mental Health OP TX: _____ Phone: _____

Psychiatrist /Doctor: _____ Phone: _____

Therapist Name: _____ Phone: _____

BCM/ASM/SC: _____
Agency: _____ Phone: _____

Peer Specialist: _____
Agency: _____ Phone: _____

Housing Specialist: _____
Agency: _____ Phone: _____

Psychiatric Evaluation

Completed By: _____ Date: _____

Medication Record

#	Medication Name	Dosage	Frequency	Used For
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Significant Medical Conditions / Disabilities (*specify):*

___ Physical (Specify):_____

___ Vision: _____

___ Hearing: _____

___ Developmental: _____

___ Illicit Drugs: Explain: _____

Alcohol Consumption: ___Social ___Moderate ___Excessive ____None

Medical Providers

Primary Care Physician: _____
Office: _____ Phone: _____

Dentist: _____
Office: _____ Phone: _____

Optometrist: _____
Office: _____ Phone: _____

Pharmacy: _____ Phone: _____

EDUCATION / VOCATIONAL TRAINING

School Name	City/State	Dates	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMPLOYMENT HISTORY

Employer	Date Start / Finished	Reason for Leaving
_____	_____	_____
_____	_____	_____
_____	_____	_____

Did the member serve in the Military? ____ Yes ___ No
If Yes: Branch: _____ Dates: _____

LEGAL ISSUES

Have you ever been arrested or placed on probation? *YES* *NO*
(Circle One Choice)

If YES, Explain:

_____
_____
_____

Charges Pending YES NO N/A
(Circle One Choice)

FINANCIAL INFORMATION

___*Social Security:* ___ *SSDI* ____ *SSI* ____ *Retirement*

___ *Department of Public Welfare (General Assistance)*
___ *Veterans' Benefits* ____ *Pension* _____*Salary* _____ *other*

Does the member have a support contact? ___ Yes _____ No

If Yes, Who is it? Name: _____
Agency: _____
Phone: _____
Contact with Family: ____ YES ___ NO
Father _____ Phone:
_____
Mother: _____Phone:
_____

Siblings: _____ Phone: _____
Husband/Wife: _____ Phone: _____
Children: _____ Phone: _____
(List Addresses if Appropriate)

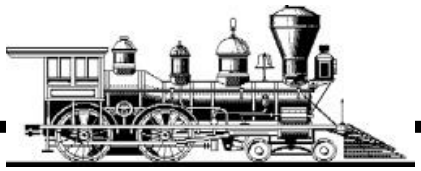
Alcohol Use: _____ Social ____ Moderate _____ Excessive _____ NONE

Past Hospitalizations:

Facility: _____ From: _____ To: _____
Facility: _____ From: _____ To: _____
Facility: _____ From: _____ To: _____
Facility: _____ From: _____ To:_____

Referral continues on the NEXT Page

Union Station Clubhouse



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CONSENT FOR SERVICES

Type of Services/Treatment
The Union Station Clubhouse program serves individuals 18 years of age and older who have a diagnosis of mental illness by a Licensed Practitioner of the Healing Arts (LPHA)in accordance to the DSM-IV and the PA State Medical Necessity Criteria. The program is guided by the International Standards for Clubhouses. Participation in the clubhouse is voluntary and not time limited. It is understood by those involved in providing Psychiatric Rehabilitation services through a Clubhouse model that every human being has something to contribute. Members choose their activities and their level of involvement. Activities and skills necessary for achieving goals, both personally and professionally, are learned and practiced daily in the work units.

Benefits/Risks
Participation in the operation of the Clubhouse through the work units is the primary method through which members are engaged in the rehabilitative process, and the primary rehabilitative tool through which recovery occurs. It is through the work units that members learn skills necessary for sustaining psychiatric stability and social and vocational functioning. The risk of the program is minimal, except for common workplace accidents/incidents.

Alternative Services/Treatment
Clubhouse staff works collaboratively with a variety of service providers and community resources. The Clubhouse works with the Intensive Case Manager (ICM), Resource Coordinator (RC) or treatment specialist from various agencies, other Community Mental Health Centers, Drop-in Centers, Mental Health Association and local hospitals (Uniontown, Highlands, etc.). Clubhouse staff participates in Team Meetings and Goal Planning, when requested.

Member Statement of Consent
By signing this document, I attest that the description of program services was explained to myself, legal representative, or guardian and that I understand the content wherein. I consent to participate in Psychiatric Rehabilitation Services through Union Station Clubhouse and Goodwill of Southwestern Pennsylvania.

Member Signature: _____Time & Date: _____

PR Practitioner Signature: _____ Date: _____

Witness Signature: _____Date: _____

Union Station Clubhouse

100 Corporate Crossing Road
Uniontown, PA 15401

Permission for Use/Disclosure of Health Information

I give my consent to _____to disclose information from my record to _____Union Station Clubhouse_____ for the purpose of:

X Determining eligibility for Union Station Clubhouse
__ Other: _____

I understand that the information released will be limited to the following marked items:

____	Diagnosis	___	General Physical
____	Attendance	_X_	Psychiatric Evaluation
____	Prognosis	____	Medications/Rx
____	Educational Goals	____	Other (please specify):
____	Vocational Goals	_____	

I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent that Union Station Clubhouse has already relied upon it, of if this Authorization was signed as a condition of obtaining insurance coverage. In order to revoke this Authorization I understand that I must do so in writing. I also understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information, and may no longer be subject to the privacy protections provided to me by law.

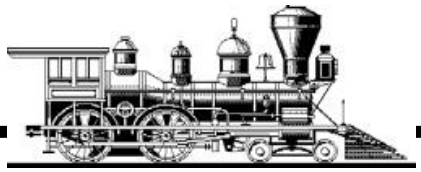
Date: _____ Signature: _____

This Authorization expires on: _____

Date: _____ Witness: _____

If you are the legal representative of the person listed above, please note the basis for your authority:
□ Power of Attorney (attach copy) □ Guardianship Order (attach copy)
□ Custody Order (attach copy)

Union Station Clubhouse



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To whom it may concern:

Please complete the attached form so the individual requesting to participate in the Union Station Clubhouse program of Goodwill of Southwestern Pennsylvania will be permitted to begin the program.

As per Pennsylvania Department of Public Welfare regulations, we are required to receive a recommendation from a Licensed Practitioner of the Healing Arts (LPHA).

An Licensed Practitioner of the Healing Arts (LPHA)must be ONLY be one of the follwling:

- The form can only be signed by one of the following:
  - Medical Doctor, Psychiatrist (M.D., D.O.)
  - Physician's Assistant (PA, PA-C)
  - Certified Registered Nurse Practitioner (CRNP)
  - Psychologist (Psy. D., Psy. ABD)

Additionally, as of January 1, 2018, the LPHA will be REQUIRED to list their PROMISEe number as well as their NPI number in order for the member to attend the program.

After completion, please FAX the form to the attention of Scott Bombach, Program Director of Union Station Clubhouse at (724) 439-9334 or mail to:

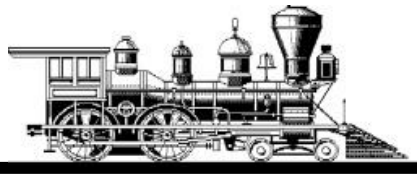
Union Station Clubhouse
100 Corporate Crossing Road
Uniontown, Pennsylvania 15401-3347

Thank you in advance for your cooperation.

Sincerely,

Scott Bombach, B.S., CPRP
Program Director
Union Station Clubhouse
Affiliate of Goodwill of Southwestern Pennsylvania

Union Station Clubhouse



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As a Licensed Practitioner of the Healing Arts (LPHA). I recommend the following individual,

_____ to be a member of Union Station Clubhouse (an affiliate of Goodwill of Southwestern Pennsylvania) to work on one of the following environments:

_____ Living ____Learning _____ Working ____ Socializing

The individual has the following Mental Health Diagnosis listed on one of the two AXIS:

AXIS I: F._____.____ / F _____.____

AXIS II: F._____.____ / F _____.____

Please write a short comment as to how the individual will benefit from participating in the Union Station Clubhouse Program:

_____

_____

_____

Printed Name & Credentials of LPHA: _____

Signature and credentials of LPHA:_____

PROMISe #; _____

NPI #: _____

Date of Signature: _____