fresh·start ann arbor

A member-led community empowering people with mental illness

Fresh Start Clubhouse Prospective Membership

Full Name: _____ **Preferred Name (if different):** _____
Preferred Pronouns: _____ **Date of Birth:** ___ / ___ / _____
Gender Identity: □ Woman □ Man □ Transgender Woman □ Transgender Man □ Other □ Non-Binary □ My Gender is not listed

Race and Ethnicity □ Alaskan Native/American Indian □ Asian □ Latino/Latina □ Black/African America (Non-Latino) □ Native Hawaiian/Pacific Islander □ White (Non-Latino) □ Mixed Race □ Middle Eastern/ North African □ Other □ Prefer to not answer □ My race/ethnicity is not listed, I identify as:_____

Do you identify as part of the LGBTQAI+ Community
□ Yes □ No □ Maybe □ Prefer to not answer □ Unsure □ Tell me more
□ My gender is not listed, I identify as: _____

Address:
Street: _____
Apartment: _____
City: _____ State: _____
Zip Code: _____

Landline Phone: _____
Mobile Phone: _____
Email: _____

Housing Type (choose one):
□ Own Home/Apartment (non-subsidized) □ Supportive Apartment
□ Home of Family Member □ Nursing Home
□ Single Room Occupancy (SRO) / Group Home (Independent Living) □ Shelter
□ Supported Apartment (Subsidized) □ Homeless/Undomiciled
□ 24 Hr. Supervised Housing □ My Housing option is not listed here. I live: _____

Do you have a history of houselessness?
□ YES □ NO

If YES, in the past 12 months?
□ YES □ NO

Please explain any houselessness history:

_____

_____

Veteran Status: Are you a veteran?
□ YES □ NO

Primary Language, If other than English:
_____

Referral Information

□ Do you identify as someone whose life has been impacted by mental illness?

□ YES □ NO If you'd like to share more (optional):_____

□ Check here if you receive services from Washtenaw County Community Mental Health

CRCT ID _____ (if available)

□ Release of Information: I, _____, give permission for Fresh Start Staff to contact my provider at _____, to access contact information for clinical care team, and to access EHR for billing and reimbursement purposes. (This approval is valid for one year from the date signed)

Self-referral: □ YES □ NO
If NO, please fill out referrer information below
Source of Referral:_____

Name of Referral:_____ Phone/Email:_____

□ Check if you've had a tour of the Clubhouse Date of Tour: _____ / _____ / _____

What is your main goal in joining Clubhouse?
□ Community/Socialization □ Education □ Employment
□ Health & Wellness □ Benefits □ Housing □ Something else:_____

Why would the Clubhouse be a good place for you?

List something(s) that may be preventing you from meeting your goals.

Emergency Contact

Name: _____
Relationship: _____
Phone #: _____

Signature:

_____

Signature of Legal Guardian/Representative:

_____

For Office Use Only

Date Received: _____ / _____ / _____

Date:

_____ / _____ / _____

Date:

_____ / _____ / _____