



A supportive clubhouse for people with a history of mental illness.

APPLICATION PACKAGE

Dear Applicant:

Thank you for expressing an interest in **Chelton Loft**, a Psychosocial Clubhouse Rehabilitation program. Please call and schedule an orientation/tour of the Loft, so you can see the clubhouse in person.

In order to expedite your journey at the Loft, there is some information needed as part of the intake process. We ask that psychiatric/medical information be completed by an MD, RN, LCSW or psychologist. Please remember that in order to be considered for membership, we need to receive all required paperwork, so it is extremely important that you forward the following items to us (preferably typed) as soon as possible.

The following three items are required to be submitted; please be sure they are within the time frames indicated.

- **Psychosocial History** (within the last three months): completed by a social worker or therapist.
- **Mental Status Exam** (within the last three months): completed by a psychiatrist.
- **Current Physical Exam** (within the last six months): completed by a medical doctor. Must include current PPD.
- **HRA Supportive Housing Eligibility & Services Determination Notice.**

After we receive this information, we will contact you to come in for trial days, during which you will take part in the work ordered day here at Chelton Loft along with other members. At the beginning of the month, if accepted, you will take part in a group orientation and become a full member of the clubhouse.

Please forward all correspondence and/or questions to the Member Services Unit at (212) 727-4364 (phone) or fax documents to (212) 727-4379. Thank you for your interest in our program and we hope to hear from you soon.

Sincerely,

Members and Staff of Chelton Loft



A supportive clubhouse for people with a history of mental illness

REFERRAL FOR MEMBERSHIP

This referral form may be completed by a Department of Mental Health (DMH) provider, psychiatrist, therapist, doctor, or the individual interested in membership at Chelton Loft. Incomplete information may result in a delay in confirmation of membership eligibility.

Date of this referral: _____ Referral completed by: _____

PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____ E-mail: _____

SSN #: _____ Medicaid #: _____

Gender: Male Female Primary Language: _____

Income Source: _____ Income Amt/Month: _____

What are your living arrangements? Are you satisfied with your current housing?

- private apartment/live alone SRO Yes No
- private/family residence Shelter
- HRA approved housing Homeless

Do you have prior involvement with Chelton Loft? Yes No

If yes, why did you leave the clubhouse? _____

KEY SUPPORT PERSON(S)

Name: _____ Name: _____

Telephone: _____ Telephone: _____

Relationship: _____ Relationship: _____

EMERGENCY CONTACT PERSON(S)

Name: _____ Name: _____

Telephone: _____ Telephone: _____

Relationship: _____ Relationship: _____

Name: _____

PSYCHIATRIC INFORMATION

Evaluation/ Assessment

Diagnosis: Axis I: _____
 Axis II: _____
 Axis III: _____

Behavioral Observations: _____

Pre-Crisis Symptoms: _____

Psychiatrist's Name: _____

Agency Name: _____

Agency Address and Phone : _____

Therapist's Name: _____

Agency Name: _____

Agency Address and Phone: _____

ICM/Case Manager: _____ Telephone: _____

Residence Worker Name: _____ Telephone: _____

Current Medications

Name of Medication(s): _____	Dosage: _____	X/day: _____
_____	Dosage: _____	X/day: _____
_____	Dosage: _____	X/day: _____
_____	Dosage: _____	X/day: _____
_____	Dosage: _____	X/day: _____

Psychiatric Hospitalizations (Most Recent)

Name of Hospital: _____

Doctor's Name: _____

Admission Date: _____ Discharge Date: _____

Reason for Admission: _____

Name: _____

GENERAL INFORMATION

1. Do you have current health problems? Yes No
Please explain: _____

2. Any history of substance abuse? Yes No
If yes, please indicate length of sobriety: 3-6 months 6-12 months 1 year or more

3. Any history of sexual abuse? Yes No

4. Any history of physical abuse? Yes No

5. Any criminal convictions? Yes No
If yes, please specify. _____

6. Are you on probation/parole? Yes No
If yes, please specify dates parole/probation will end. Month _____ Day _____ Year _____

8. Parenting Skills: Are you the primary caregiver for any minor child/children in the home? Yes No

If yes, how does your disability affect your ability to perform routine childcare?

Is there a history of ACS involvement now or in the past?
If yes, please explain. _____

7. What hobbies/social activities do you like or get involved in?

8. Which unit are you most interested in volunteering in:
 Membership Café Employment Administrative
 Foundations Housing Education Health and Wellness

9. Goals: What would you like to accomplish at Chelton Loft?

10. Roadblocks: List roadblocks to meeting your goal. What will you need help with? What are your fears about accomplishing the above goal?

Name: _____

CHELTON LOFT DEMOGRAPHIC INFORMATION

Please complete the information below. This information will assist Chelton Loft and its parent agency Fedcap to gather statistical information that will be helpful to obtain funding and to continue its programs.

Member Name: _____ Date: _____

GENDER: Female Male AGE GROUP: 17-21 22-44 45-64 65+

ETHNIC BACKGROUND:

- African-American
- Hispanic
- Asian
- Caucasian
- Multi-Racial
- Other

RESIDENCE:

- Manhattan
- Bronx
- Brooklyn
- Queens
- Staten Island
- Other

EDUCATION:

- Some high school
- HS diploma/GED
- Vocational School
- Beyond High School

Medical Alerts: _____

Do you have more than one disability? If so, please describe:

- Have you been convicted of a crime? Yes No
- Have you worked in the last two years? Yes No
- Is English your native language? Yes No

FINANCIAL SUPPORT:

- SSI
- Family
- Public Assistance
- Other
- SSD
- Self
- Employment

MEDICAID NUMBER: _____



A FEDCAP PROGRAM

AUTHORIZATION FOR DISCLOSURE AND PROCUREMENT OF PROTECTED HEALTH INFORMATION

Member Name: _____

Date of Birth: _____

Social Security #: _____

I (named above) authorize the release and procurement of protected health information between Chelton Loft and the agency/person listed below.

Name: _____

Address: _____

Telephone: _____

Specific information to be released and obtained:

- Mental Status Exam
- Psychosocial Assessment
- Discharge Summary
- Medical Records
- Lab Results
- Other _____

- For purpose of:
- Intake
 - Employment Assistance
 - Coordinating Treatment
 - Legal Use
 - Continued Treatment
 - Other _____

I hereby permit the release or disclosure of the above information to the following person/organization/facility/program(s) identified above. I understand that:

- Only this information may be used and/or disclosed as a result of this authorization.
- This information is confidential and cannot be legally disclosed/released without my permission.
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
- I have a right to revoke this authorization at any time. My revocation must be in writing.
- I do not have to sign this authorization and my refusal to sign will not affect my abilities to obtain treatment from the NYS Office of Mental Health, nor will it affect my eligibility for treatment.
- The authorization is valid for 90 days from the date signed.
- I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR S 164.524)

Member Name

Member Signature

Date

Witness Name

Witness Signature

Date

Name: _____

CHELTON LOFT PHYSICAL EXAMINATION FORM

Patient Name: _____ Gender: Female Male

Address: _____ Age: _____ Weight: _____

Phone #: _____ Pulse: _____ BP: _____

Physical Exam (Please check any condition that applies to patient)

CONDITION	YES	NO	N/A	EXPLANATION
Allergy				
Skin				
Heart				
Abdomen				
Respiratory				
Genital				
Urological				
Neurological				
Ear, Nose, Throat				
Rectal				
Diabetic				
Musculoskeleton				

Laboratory Data Results (if applicable, please check)

TEST	NORMAL	ABNORMAL	EXPLANATION
PPD			
EKG			
Chest X-ray			
Urinalysis			
Hepatitis Profile			

Psychotropic Medications (if applicable)

MEDICATIONS	DOSAGE	FREQUENCY

Signature/Stamp

Printed Name

Date

Name: _____

CHELTON LOFT'S MEMBER NUTRITION AND DIET INFORMATION

(To be filled out and signed by physician)

Member's Name: _____

Date: _____

Physician's Name: _____

Physician's Signature: _____

1) Does patient have any of the following medical conditions? Please check "yes" or "no".

MEDICAL CONDITION	YES	NO
High Blood Pressure		
High Cholesterol		
Diabetes/Prediabetes		
Obesity		

2) Does patient have any allergies to the following foods?

FOODS	YES	NO
Dairy/lactose		
Eggs		
Wheat/Gluten		
Nuts		
Shellfish		
Pork		
Other (please list)		

3) Has patient been prescribed any of the following diets?

TYPE OF DIET	YES	NO
Low Salt		
Low Sugar		
Low Calorie		
Low Fat		
Gluten Free		

4) Does patient take MAO inhibitors (a type of antidepressant?) Yes No



Housing Status

Fedcap Rehabilitation Services, Chelton Loft division must track our active members' housing status according to New York's Human Resource Administration (HRA) eligibility and/or acceptance. In order to ensure that our housing records are kept up to date, we are requesting that Chelton Loft members who live in HRA housing complete the following information.

Member Name: _____

Residence Name (if applies): _____

Street Address: _____

City/State/Zip Code: _____

Housing Determination level: _____

Contact Staff Person: _____

HRA Levels of Housing:

A- Community Care

Supported Housing Program

Supported Single Room Occupancy Residence (Supported SRO)

* Tenants have independent living skills, buildings have little on-site supervision and/or support and are permanent housing units.

B- Level I

Family-Type Home for Adults (Adult Foster Care)

* Tenants are unable to live independently, there is on site supervision and are deemed long term care units.

C- Level II

Community Residence/Single Room Occupancy (CR/SRO)

Apartment Treatment Program (formerly known as Intensive-Supportive & Supportive Community Residences)

Supervised Community Residence (SUPER/CR)

MICA Community Residence (MICA/CR)

Residential Care Center for Adults (RCCA)

Residence for Adults (RFA)

Private Proprietary Home for Adults (PPHA) (also known as Adult Home)

* These units are designed for tenants who require a high level of support, independence living skills training and on site supervision

Determining "On- Site" Official: _____ Date: _____



PHOTO RELEASE FORM

Please check off whether you **GIVE** or **DO NOT GIVE** permission.

I, _____, of Chelton Loft hereby
(Your Name)

GIVE PERMISSION or **DO NOT GIVE PERMISSION**

to Fedcap to use the photo/s and/or video/film footage taken of me for Fedcap's use for internal publications and for promotion, outreach, and development of it's program and services. Such use may include promotional displays, newsletters or bulletins, brochures, annual reports, display advertising, direct mail fundraising appeals, or internet use by Fedcap only. Any other use is prohibited unless specific permission is granted by me.

Signed: _____

Date: _____



CHELTON LOFT/FEDCAP REHABILITATION SERVICES STATEMENT OF UNDERSTANDING

To Our Members:

We are pleased to have you participate in our program or employment at Fedcap’s clubhouse, Chelton Loft. Chelton Loft provides a safe and secure place to address your individual issues and to assist you to be prepared and able to complete your program, which may include gaining employment. We will take every precaution to protect your confidentiality and will respect the confidentiality of your relationship with Fedcap as far as possible.

We do not discuss your situation with anyone except for the reasons mentioned below which are in compliance with Federal law or unless you give us written permission to do so:

1. If we learn of any alleged child abuse or neglect or abuse of an elderly person. We are required by law to report this to the State Child Abuse Registry or State Adult Protective Services.
2. If in our judgment a consumer is a danger to himself/herself or others, we may need to break confidentiality to prevent any criminal act.
3. If we are required to present records and/or a counselor to comply with a court order, a subpoena or other legal requirements.

Member Name (please print)

Member Signature

Staff Signature

Date



CheltonLoft

Chelton Loft is a voluntary clubhouse program for adults with a history of mental illness. It is part of Fedcap, a nonprofit organization that has been a leader in developing training and employment programs for people with disabilities and other significant barriers to employment since 1935.

Fedcap helps America work. Fedcap's mission is to empower people with barriers to move towards economic independence as valued members of the workforce. From the visually impaired, to returning veterans, to youth transitioning out of foster care, Fedcap enables individuals to support themselves, be part of a community, and enjoy the sense of accomplishment that comes from work. Through training, job placement, and *socially responsible outsourcing services™* to business and government, Fedcap has helped thousands of people transform their lives and successfully enter the workforce. Founded in 1935, Fedcap is celebrating 75 years of service in 2010. To learn more about Fedcap, or to make a donation, please visit www.fedcap.org or call (212) 727-4200.



Dear Parent, Guardian or CACFP Participant:

Your program participates in the Child and Adult Care Food Program (CACFP) and serves nutritious meals each operating day. The information requested on the Income Eligibility Form determines how much reimbursement your program will receive from CACFP for these meals and snacks, based on the United States Department of Agriculture (USDA) family income criteria listed below. We encourage you to complete the form promptly so your center can maximize its reimbursement for healthy meals and snacks. One form needs to be completed for each household every year. All information on the form will be confidential and used only for the purpose of determining CACFP reimbursement for meals and snacks served at the program.

Guidelines for completing the Income Eligibility Form are listed below:

DOH-3688: Income Eligibility Form for Child Care Centers

- Households in which any member currently receives Food Stamps, Temporary Assistance to Needy Families (TANF), or participates in the Food Distribution Program on Indian Reservations (FDPIR) are automatically eligible for the highest reimbursement and need only complete Section A of the application.
- Head Start participants are automatically eligible for the highest rate of reimbursement from CACFP. No Income Eligibility Form needs to be submitted.
- Foster children are automatically eligible for the highest rate of reimbursement from CACFP. Households with both foster and non-foster children in day care may complete one form, including the foster child as a household member. Eligibility determination for the non-foster children will be based on the information reported on the form by the household.

DOH-3834: Income Eligibility Form for Adult Day Care Centers

- Adult participants who live in a household in which any member currently receives Food Stamps, TANF, participates in FDPIR, or adults who themselves receive SSI or Medicaid, are automatically eligible for the highest reimbursement and need only complete Parts 1 and 3 of the form.

**INCOME ELIGIBILITY GUIDELINES
 (Effective July 1, 2011 until June 30, 2012)**

Household Size	REDUCED PRICE MEALS		
	Year	Month	Week
1	20,147	1,679	388
2	27,214	2,268	524
3	34,281	2,857	660
4	41,348	3,446	796
5	48,415	4,035	932
6	55,482	4,624	1,067
7	62,549	5,213	1,203
8	69,616	5,802	1,339
For each additional family member	+7,067	+589	+136

 Sponsor/Center Official

 Sponsoring Organization

 Date

No person will be discriminated against because of race, color, national origin, sex, age or disability in the operation of the Child and Adult Care Food Program. If you believe that you have been discriminated against, write to USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (866) 632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

See INSTRUCTIONS on reverse.

CENTER NAME: _____

Name of Adult in Care: _____

PART 1 Complete this PART if anyone in your household receives Food Stamps, TANF, FDPIR or if you receive SSI or Medicaid benefits. Then skip to PART 3.

Food Stamp Case Number _____ or

TANF Number _____ or

FDPIR Number _____ or

SSI Case Number _____ or

Medicaid Case Number _____

PART 2a Complete this PART only if you did not complete PART 1. List yourself, your spouse and any dependents that live in your household. Then list all income received last month in your household.

NAME OF HOUSEHOLD MEMBERS	Gross Earnings (Before Deductions)		Monthly Welfare Payments, Child Support	Monthly Income From Pension, Retirement, Social Security	Any Other Monthly Income
	JOB #1	JOB #2			
1. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
3. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
4. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
5. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

PART 2b If PART 2a is completed, this form must provide the name and Social Security Number of the adult who signs PART 3. If the adult does not have a Social Security Number, print *none* in the space provided.

Name _____ Social Security Number

X	X	X	-	X	X	-						
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PART 3 After reading the following statement and the statement on the back, sign below.
 I certify that the above information is true and correct and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____ Date _____

FOR SPONSOR USE ONLY Sponsor Number _____

Total Household Members _____ Total Income \$ _____

Free _____ Reduced _____ Paid _____

Signature of Center Staff _____ Date Determined ____/____/____