COMMUNITY CORNER
CLUBHOUSE
Opening the Door to Hope, Recovery & Opportunity for People with Mental Illness

Community Corner Clubhouse Membership

The Clubhouse vision is that people with mental illness everywhere achieve their potential and are respected as co-workers, neighbors and friends.

To be referred for Membership the Membership Referral Form must be completed.
We require a primary mental health diagnosis from a MD, Psychiatrist or Psychologist.

To be eligible for membership an applicant:

1. must have a primary presenting problem associated with severe and persistent mental illness.

2. should be interested in attending Community Corner Clubhouse, since participation is voluntary.

3. who has a history of substance abuse must be clean and sober for at least 30 days.

4. cannot pose a threat to our community.

5. must be at least 18 years of age. There is no upper age limit.

Please note we *do not* accept referrals for housing.

If you have any questions or need assistance please contact the
Intake/Membership Office at (715) 843-1926

North Central Health Care
Person centered. Outcome focused.

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Community Corner Clubhouse Membership Referral Form

DATE: _____

MEMBER INFORMATION

NAME: _____ DOB: _____ NCHC NO: _____ *(If known)*

PHONE: _____ LEAVE MESSAGE? ☐ YES ☐ NO

CELL PHONE: _____ LEAVE MESSAGE? ☐ YES ☐ NO

BEST TIME TO CONTACT: _____

ADDRESS: _____

COUNTY OF RESIDENCE: ☐ MARATHON ☐ LINCOLN ☐ LANGLADE

MEMBER IS BEING REFERRED BY:

ORGANIZATION AND/OR PERSON NAME: _____

PHONE: _____

EMAIL: _____

DO WE HAVE PERMISSION TO SEND YOU COMMUNICATION SUCH AS NEWSLETTERS AND UPDATES VIA EMAIL? ☐ YES ☐ NO

RELEASE OF INFORMATION INCLUDED? ☐ YES ☐ NO

FOR ALL REFERRALS FROM OUTSIDE NCHC, PLEASE INCLUDE A RELEASE OF INFORMATION TO CONTACT PRIMARY CARE PHYSICIAN/PSYCHIATRIST.

REASON FOR REFERRAL:

☐ MEDICATION ASSISTANCE ☐ BENEFITS COORDINATION ☐ ACTIVITIES OF DAILY LIVING ASSISTANCE

☐ SYMPTOM MANAGEMENT ☐ SUBSTANCE ABUSE ☐ EMPLOYMENT/EDUCATION ASSISTANCE

☐ SOCIAL/RECREATIONAL ☐ COMMUNITY SUPPORT ☐ OTHER _____

PLEASE ELABORATE: _____

_____

_____

_____

DIAGNOSIS (IF KNOWN) **AXIS I:** _____

AXIS II: _____

DOES THE REFERRAL HAVE A CURRENT AODA OR MENTAL HEALTH COMMITMENT? ☐ YES ☐ NO

DOES THE REFERRAL HAVE A GUARDIAN? ☐ YES ☐ NO

GUARDIAN NAME: _____ GUARDIAN PHONE: _____

GUARDIAN ADDRESS: _____

PAYOR SOURCE: ☐ MEDICAID *(BadgerCare, Foward Health, etc.)* ☐ MEDICARE ☐ PRIVATE INSURANCE ☐ SELF-PAY

PRIMARY PHYSICIAN/PSYCHIATRIST/PSYCHOLOGIST:

_____

PLEASE MAIL OR FAX FORM TO:

COMMUNITY CORNER CLUBHOUSE
Membership Services
811 N. Third Avenue
Wausau, WI 54401
PHONE: 715-843-1926
FAX: 715-261-0312