OASIS HOUSE
Rebuilding lives within the community.
751 S. Queen St., York, PA 17403 Phone: 717-848-3566 Fax: 717-848-3766

# OASIS HOUSE REFERRAL

A potential member must be **at least 18 years of age** and have a **major mental health diagnosis (Post-Traumatic Stress Disorder, Anxiety, Schizophrenia, Major Depression, Bipolar Disorder, Psychotic Disorder, Schizoaffective Disorder, and/or Borderline Personality Disorder) verified by a Licensed Practitioner of the Healing Arts (LPHA). An LPHA is limited to a physician, physician's assistant, certified registered nurse practitioner, and psychologist.** Please have the LPHA fill out page 4 with his/her signature and date to verify and may include a Psychiatric Evaluation which was done within the last year that specifically states the LPHA's recommendation for Clubhouse services. Also required is a moderate to severe functional impairment due to MH symptoms in at least one of the following domains: **Living, Illness/Wellness, Social, Educational, and/or Vocational**. If the individual doesn't meet diagnosis requirements, they can request an exception by getting a written recommendation from the LPHA including a diagnosis of mental illness and a description of the functional impairment resulting from the mental illness. The LPHA should write that they recommend the individual receive clubhouse services.

**This referral must be filled out completely with all spaces addressed, otherwise, it may not be processed. The Clubhouse has control over its acceptance of new members.**

## Identifying Information

**Full Name:** _____ **Date of Birth:** _____ **Phone:** _____

**Address:** _____ **SS#:** _____
**Street**

_____ **BSU#:** _____
**City, State & Zip Code**

**Case Manager:** _____ **Phone:** _____

## Current Living Arrangement

**Marital Status:** _____ Single _____ Widowed _____ Cohabitating
_____ Married _____ Separated
_____ Divorced _____ Annulled

**Current Housing:** _____ Hospital _____ Jail/Prison _____ Living Independently _____ Street/Outdoors
**You may check more than one** _____ Living w/Family _____ Living w/Others _____ Nursing Home
_____ Personal Care Home _____ Residential Treatment _____ Shelter

**Emergency Contact Name:** _____ **Phone:** _____
**Relationship:**
_____ **Release Signed:** _____ Yes _____ No

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**Referral Name:** _____

## Insurance Information

**MA/Medicaid:** ___ Yes ___ No **If yes, MA #** _____

**Insurance Provider:** _____ **ID #:** _____

**Medicare:** ___ Yes ___ No **If yes, ID #:** _____

**Other Insurance:** _____ **ID#:** _____

**County Financial Liability:** ___ Yes ___ No

## Personal Data

**Gender:** ____ Female ____ Male ____ Non-binary

**Race:** ____ Black/ African American ____ American Indian/Eskimo ____ Asian/Pacific Islander ____ Bi-racial ____ Other ____ White/Caucasian

**Ethnicity:** ____ Hispanic/Latino ____ Non-Hispanic/Latino

**Were you ever in the military?** ____ Yes ____ No

**Did you complete High School/GED?** ____ Yes ____ No

**Did you attend a Trade School or Vocational School?** ____ Yes ____ No

**Did you receive a certificate?** ____ Yes ____ No

**If yes, what was the course of study?** _____

**Did you attend college?** ____ Yes ____ No

**How many years did you complete?** _____

**What was your major?** _____

**Did you graduate?** ____ Yes ____ No

**Year:** _____ **Degree:** _____

**Source of Income:** ____ SSI ____ SSDI ____ Employment ____ VA ____ Pension ____ Other. Please specify. _____

**Total Monthly Income:** _____ **Do you receive food stamps?** ____ Yes ____ No **What amount do you receive?** _____

**Are you currently employed?** ____ Yes, note below ____ No

**Present Employer:** _____ **How Long:** _____

**Past Employers:** **Name** **Dates of Employment**

1) _____ _____

2) _____ _____

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**Referral Name:** _____

**Have you ever been arrested?** ____ Yes ____ No
If yes, please give details and specify dates, probation, parole and if it was a violent crime:

_____

_____

_____

**Currently on parole/probation?** ____ Yes ____ No If yes, please provide name and contact number.
**Parole/Probation Officer:** _____

**Medical conditions (physical disabilities, seizures, allergies, heart condition, diabetes, etc.)**

_____

_____

**Do you have a history of substance abuse/dependence?**
**If yes, please specify:** _____
**In recovery?** ____ Yes ____ No **If so, for how long?** _____
**Are you actively participating in a recovery program?** ____ Yes ____ No
**Program:** _____ **Anticipated date of completion:** _____

**Areas of interest/need for clubhouse involvement. You may check more than one.**

_____ Employment/Job Skills
_____ Housing/Living Skills
_____ Social Engagement/Network
_____ Education
_____ Physical/Mental Health Education
_____ Other. Please specify. _____

**By signing this form, you are verifying the above listed information is true to the best of your knowledge.**

**Signature of Referral:** _____ **Date:** _____
**Printed Name:** _____

**Signature of Referral Source:** _____ **Date:** _____
**Printed Name:** _____ **Phone #:** _____

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# OASIS HOUSE VERIFICATION OF DIAGNOSIS FORM

**Referral Name:** _____ **DOB:**_____

**To Be Completed by A Licensed Practitioner of the Healing Arts (LPHA):** An LPHA is limited to a physician, physician's assistant, certified registered nurse practitioner, and psychologist. (MD, DO, PA, CRNP, PsyD, PhD)

Psychiatrist: _____ Agency: _____ Phone #: _____
Therapist: _____ Agency: _____ Phone #: _____
Case Manager: _____ Agency: _____ Phone #: _____

**Diagnoses:** To qualify for clubhouse services the referral must have a major mental health diagnosis of Post-Traumatic Stress Disorder, Anxiety, Schizophrenia, Major Depression, Bipolar Disorder, Psychotic Disorder, Schizoaffective Disorder, and/or Borderline Personality Disorder. An exception to diagnostic criteria may be accepted with a letter from the LPHA.

**Primary BH Diagnosis:** _____ **ICD 10 Code:** _____
**Secondary BH Diagnosis:** _____ **ICD 10 Code:** _____
**Additional Diagnosis:** _____ **ICD 10 Code:** _____
**Additional Diagnosis:** _____ **ICD 10 Code:** _____

**Psychiatric Medication(s):** List name and dosage.

1. _____ 3. _____
2. _____ 4. _____

**Substance Use:**

**Does the prospective member have a history of substance abuse or dependence?** ___ Yes ___ No
**If yes, please specify:** _____
**In recovery?** ___ Yes ___ No **If so, for how long?**
**Is he/she actively participating in a recovery program?** ___ Yes ___ No
**Program:** _____ **Anticipated date of completion:** _____

**Hospitalizations:** List hospitalizations within the past 12 months.

| | Hospital | Year | Length of Time |
|---|---|---|---|
| 1. | | | |
| 2. | | | |

**By signing below, you are verifying that you are a current Licensed Practitioner of the Healing Arts (LPHA) and have completed this form with the intent of the individual listed above to receive services from the Oasis House.**

**LPHA Signature** _____ **Date** _____
**Printed Name with credentials** _____ **Phone** _____

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