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 (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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Incomplete referrals will not be processed for membership

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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 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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