



**Thank you for your interest in Vincent House.  
We are looking forward to you becoming a member soon!**

Most likely, your first experience of Vincent House will be a tour of the Clubhouse. If you are interested in joining, you will be provided with all the necessary paperwork. Please be patient with this process, as it often requires a bit of time and perseverance. We suggest that you read the Member Handbook and familiarize yourself with the Clubhouse experience. You will find that we are a community dedicated to promoting and celebrating our members' recovery from mental illness.

It is necessary that we obtain all the required paperwork prior to scheduling your orientation session. Prospective members can fill-out the New Member Information Form on their own or request assistance from health providers, case managers or family members. Incomplete information may delay the intake process. If you have any questions about the intake and orientation process, please call the Member Services Unit at 727-541-0321. You will be contacted and scheduled for a 4-day Orientation Session once you have taken a tour of Vincent House and submitted the following:

- 1. New Member Information Form**
- 2. Signed Release of Information**
- 3. Vincent House Referral signed by psychiatrist**
- 4. Recent Psychiatric Evaluation (last two years)**

**VINCENT HOUSE  
4801 78<sup>TH</sup> AVENUE NORTH  
PINELLAS PARK, FL 33782**

**TEL: (727) 541-0321  
FAX: (727) 541-0355  
[www.vincent-house.org](http://www.vincent-house.org)**



**HOUSING STATUS**

(check all that apply)

- Alone                       ALF                       Group Home                       Adult Foster Care
- Hospital                       Homeless                       Supported Housing                       Nursing Home
- Share housing with relatives:                      Cost share:     Yes                       No
- Share housing with non-relatives:                      Cost share:     Yes                       No

How many people live in your household? \_\_\_\_\_ Are you a single parent?  Yes  No

Number of children under 18 years old? \_\_\_\_\_

List the people in your household:

- spouse                       father                       mother                       son(s) \_\_\_\_\_                       daughter(s) \_\_\_\_\_
- grandmother                       grandfather                       other relative(s) \_\_\_\_\_                       friend(s) \_\_\_\_\_

**TRANSPORTATION**

How will you arrive to Vincent House?  public transportation     by taxi     walk / bicycle     drive own car  
 Do you have a Driver's License?  Yes  No

**EMPLOYMENT**

Current Employment:                       part-time     full-time     unemployed  
 Future Goals:                       maintain current job     obtain part-time job     obtain full-time job     not seeking paid work

***If currently employed:***

Employer: \_\_\_\_\_ Employer Address \_\_\_\_\_  
 Employer Phone \_\_\_\_\_ Type:  clerical     management     professional     retail     sales

***If you are not currently employed, what do you do during the day?*** \_\_\_\_\_

**WORK HISTORY:**

<b>Dates</b>	<b>Employer</b>	<b>Job Title - Type of Work</b>	<b>Hours/week</b>	<b>Pay/hour</b>

Estimate number of paid jobs you have had: \_\_\_\_\_ Estimate number of years you have worked for pay: \_\_\_\_\_

Are you involved with VR (Vocational Rehabilitation)?  Yes  No If yes, Counselor is \_\_\_\_\_

Are you enrolled in Supported Employment?  Yes  No If yes, agency is \_\_\_\_\_

**INCOME**

(check all that apply and enter monthly amounts)

- children \$ \_\_\_\_\_     child support \$ \_\_\_\_\_     family support \$ \_\_\_\_\_     friend support \$ \_\_\_\_\_
- parents \$ \_\_\_\_\_     OSS \$ \_\_\_\_\_     public assistance \$ \_\_\_\_\_     veteran's benefits \$ \_\_\_\_\_
- retirement \$ \_\_\_\_\_     social security \$ \_\_\_\_\_     spouse \$ \_\_\_\_\_     SSDI \$ \_\_\_\_\_
- SSI \$ \_\_\_\_\_     wages \$ \_\_\_\_\_     other \$ \_\_\_\_\_

Do you have a REP PAYEE?  Yes  No If yes, Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**LEGAL HISTORY**

(Please answer all questions)

Have you ever been in jail?  Yes  No

Have you ever been in prison?  Yes  No

Have you ever been convicted of a misdemeanor?  Yes  No

Have you ever been convicted of a felony?  Yes  No

Have you ever physically injured anyone?  Yes  No

If you answered yes to any of these questions, please indicate dates, causes and outcome: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL**

(check all that apply)

asthma  chronic pain  diabetes  hearing impairment  hypertension

physical impairment  recent surgery  seizure disorder  visual impairment  other \_\_\_\_\_

Allergies/medical alert: \_\_\_\_\_

**MEDICATIONS:**

Medications	Dosage	Time	Medications	Dosage	Time
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

**RECENT HOSPITALIZATIONS:**

Name of Hospital	Admission Date	Discharge Date

Do you have a history of dependency on alcohol or other drugs?  Yes  No

If yes, please indicate substances: \_\_\_\_\_

Have you ever been in treatment for use of alcohol or other drugs?  Yes  No

Are you currently in treatment or in a support group?  Yes  No

How long have you been "clean and sober"? \_\_\_\_\_ years \_\_\_\_\_ months

**Insurance Information:**

Medicaid:  Yes  No Number/Provider: \_\_\_\_\_

HMO \_\_\_\_\_  Value Options  Fee for Service \_\_\_\_\_

Medicare:  Yes  No Number/Provider: \_\_\_\_\_

Other Insurance:  Yes  No If yes, NAME: \_\_\_\_\_ member/group #: \_\_\_\_\_

Address: \_\_\_\_\_ phone: \_\_\_\_\_

**EMERGENCY CONTACTS**

**Primary contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city)

\_\_\_\_\_  
(state)

\_\_\_\_\_  
(zip code)

\_\_\_\_\_  
(phone number)

**Secondary contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city)

\_\_\_\_\_  
(state)

\_\_\_\_\_  
(zip code)

\_\_\_\_\_  
(phone number)

**PROVIDER INFORMATION**

**CASE WORKER/MANAGER:**

Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (state) (zip code) (phone number)

**THERAPIST:**

Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (state) (zip code) (phone number)

**PSYCHIATRIST:**

Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (state) (zip code) (phone number)

**PRIMARY CARE MD:**

Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (state) (zip code) (phone number)

**PROSPECTIVE MEMBER**

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)