Empowerment Clubhouse

Provider Verification Form for Member Eligibility

Please supply the following information for ____(Client Name)

Client Phone Number:____________________________________

NOTE: To be eligible to join the Empowerment Clubhouse, members must have one of the following diagnoses:

AXIS I ☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Bipolar Disorder ☐ Major Depressive Disorder

☐ PTSD ☐ Generalized Anxiety Disorder ☐ OCD ☐ Misc. Behavioral Disorder

AXIS II (Must also have one of the above listed Axis I diagnoses) ____

AXIS III ____

Does the client have a substance use history? ☐Yes ☐No If Yes, Please Describe:____________________________

____

Client is following through with treatment, such as showing up for appointments and following medication protocol.
☐Yes ☐No Comments:____

____

Clients are expected to participate in the Work-Ordered Day. Client can follow directions, participate in vocational activities, safely socialize with others and appropriately self-regulate. ☐Yes ☐No If No, Please Explain:

____

Does client pose a significant and/or current threat to the general safety of the Clubhouse community? ☐Yes ☐No

Comments: ____

____

Has client assaulted another person in the last 12 months? ☐Yes ☐No

If Yes, please describe and include date(s) of incident(s) ____

____ Printed Full Name of Physician, Case Manager or Therapist

_________________________________ Phone Number

____ Signature of Physician, Case Manager or Therapist

_________________________________ Date

PLEASE NOTE: THIS FORM CANNOT BE RETURNED IN PERSON - IT MUST BE MAILED OR FAXED!

Return by mail to: Empowerment Clubhouse 441 Drake Avenue, Marin City CA 94965

Return by fax to: (415) 332-0337 **If questions, please call: (415) 339-2837**

Admin. Staff Signature: ______________________ Print: ____________________________Date: _____________

Revised 8/2022