

For Office Use Only
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Our Space Membership Application

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Date of Birth: _____ Sex: M _____ F _____ Veteran: Y _____ N _____

Ethnic Origin: Wht. _____ Blk. _____ Hispanic _____ Native Amer. _____ Asian _____ Other _____

Mental Health Care Provider _____

Mental Health Care Provider Telephone Number _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Member Agreement Contract

I understand membership in Our Space, Inc. is for people living in Milwaukee County, who are experiencing, or have experienced a mental illness. All members must have a primary diagnosis of mental illness. Our Space, Inc. is not an adult day care facility. Members must be at a level of functioning, which requires no staff assistance. I understand that my signature on my application indicates that I meet these requirements.

I agree to abide by the rules that I read and signed of Our Space, Inc.

I understand that Our Space, Inc. must receive a referral letter signed by a mental health professional in order to become a member.

I agree to participate in the planning and management of the center to the best of my ability, including attendance at membership meetings.

Applicant's Signature

Date

Our Space, Inc. 525 W. Lincoln Ave. Milwaukee, WI 53207 (414) 383-8921

Do you have any significant medical conditions (such as history of seizures, heart condition, diabetes, allergies to medications, etc.)?

No _____ Yes _____

If yes, please explain _____

Do you smoke? No _____ Yes _____

Alcohol and Drugs:

Have you ever had a problem with drugs and/or alcohol? No _____ Yes _____

Are you currently using alcohol and/or non-prescription drugs? No _____ Yes _____

Is yes, are you interested in obtaining information about alcohol and/or drug treatment?

No _____ Yes _____

Benefits:

Are you currently receiving benefits from any of the following? (Please check all that apply)

Title 19 _____ SSI _____ SSDI _____ VA _____ Welfare _____

Rent Assistance _____ Other _____

Activities:

Are you currently involved in any of the following? (Check all the apply)

_____ Our Space

_____ Day Hospital (county)

_____ Curative Rehab

_____ Milwaukee Center for Independence

_____ M.A.T.C.

_____ Grand Avenue Club

_____ Goodwill Industries

_____ DVR

_____ Community Support Program

_____ Education

Education:

Highest Grade Completed in school? _____

Would you like to participate in the education program? No _____ Yes _____

Would you like to participate in our computer-training program? No _____ Yes _____

How will you be getting to and from Our Space?

_____ Own car

_____ City Bus

_____ Van/care cab

_____ Other: _____

If you will be transported by a van service, please list the company name and phone number here:

How did you hear about Our Space? (Please check all that apply)

Psychiatrist CSP Family Member Therapist Friend Grand Avenue Club Case Worker Day Treatment Program Clergy Member Outreach worker Our Space member Other

We understand that you may be sensitive about providing the following information. It is however, essential to help us in programming and is required to develop statistics for funding sources. This information will be kept confidential and personal information and photographs will not be released without your consent.

Mental Health:

Have you ever been hospitalized for mental illness? No Yes

If yes, when (the year) was your last hospitalization? _____

Are you currently involved in a treatment program (day treatment, psychiatrist, psychologist, social worker, or community held groups)? No Yes

Housing:

Do you currently have permanent housing? No Yes

If yes, do you live in a:

Group home Apartment House Nursing Home With your family Rooming House Other: _____

Employment:

Are you currently employed? No Yes

If yes, do you have a:

full-time job part-time job temporary job

If no, would you like to be working? No Yes

If you would like to work, what kind of job assistance from Our Space would you find helpful?

Family:

Do you have any children? No Yes If yes, what is/are their age(s)? _____

Are the children currently in your care? No Yes

Have the children ever been removed from your care? No Yes

Have you ever been married? No Yes

Would you be interested in participating in our Parents With Out Children (PWOC) Program?

No Yes

Our Space member medication survey

(Optional) Name _____

What medications are you currently taking for your mental illness?

What medications have you taken in the past year for your mental illness?

What mental illness have you been diagnosed with?

To Whom It May Concern:

_____ has provided us with your name as a reference from a mental
(Name of Applicant)
health professional to verify his/her eligibility for membership with Our Space, Inc.

Our Space provides social, pre-vocational and educational opportunities for members as well as referral assistance with housing, employment, financial and legal matters, etc. In addition, Our Space, Inc. provides members a non-threatening atmosphere where they can come and socialize freely with other members.

If you have any questions concerning Our Space, Inc, please feel free to contact 414-383-8921.

Thank you,

Our Space Staff

I give Our Space, Inc. permission to contact the below reference in regards to eligibility for membership with Our Space.

_____ Name of reference	_____ Relationship
_____ Address	_____ Telephone
_____ Applicant's Signature	_____ Date

I, _____ verify that _____
(Name of Mental Health Professional) (Applicant's Name)

has been diagnosed with _____
(Mental Illness Diagnosis)

and therefore qualifies for membership with Our Space, Inc.

_____ Signature of Mental Health Professional	_____ Date
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Rules and Regulations

The following are not designed to restrict personal rights and activities, but to ensure that the rights and property of ALL are respected. Disciplinary action will result if the following rules are not adhered to.

No smoking outside . Smoking in designated smoking room only.

Must ask staff before changing radio station and/or volume level.

No swearing.

No sleeping.

No threats or acts of physical, material or verbal violence or abuse.

No sexual harassment, verbal or physical, toward staff or members.

No theft. Theft will lead to automatic expulsion.

No wandering upstairs or into areas not designated for the use of Our Space members.

No being under the influence of alcohol and/or controlled substances.

No possession of weapons.

No begging members for money, beverages, food or cigarettes here or at any of the restaurants across the street from Our Space, Inc. You may ask, but if member says no and you ask again, it is begging.

No leaving your mess for others to clean up.

Coffee to be made by appointed members only.

The back door is not an entrance/exit

Members must wear seat belt at all times when traveling with our Space on outside activities.

There is no eating or drinking on the carpeted areas with the exception of water. You may drink water anywhere. You may not bring anything into the smoking room.

No abusing the pool table or pool cues.

It is the responsibility of the staff to enforce these rules. So if you have a problem or see someone not following these rules, please report it to staff immediately.

I have read the rules and my signature is an indication that I agree to abide by the rules.

Signature: _____

What will I gain from Our Space?

- Learn to improve socialization skills
- Create and maintain a network of peers
- Relax and enjoy healthy affordable fun
- Learn skills through participation in the educational groups
- Work in paid pre-vocational positions through Blue Dove gift shop, member outreach and janitorial services
- Receive support through weekly groups

Why should I recommend people to Our Space?

- Our Space provides social, recreational, educational and pre-vocational activities
- Members develop positive peer support networks
- Increase independence and raise self-esteem through active participation in activities and groups
- Our Space, Inc. is a “member driven” organization, which allows for each individual to express needs and help plan group activities
- Opportunity to become a Board member and set policies on important issues and concerns
- Only criteria for membership is a diagnosis of a mental illness
- Members choose the degree of involvement and participation they can handle. Our only expectation is that they follow the rules and regulations for the center.

Member Process

- Potential members required to fill out application, which includes a reference letter
- Reference letter needs to be signed by a mental health professional such as a case manager, a social worker, a therapist, a psychologist or psychiatrist, et al.
- Upon receipt of reference letter, individuals will be notified of membership and can attend
- Potential members are encouraged to attend **New Member Orientation** during application process to see if the services that we provide at Our Space will work for them.

Activities Interest

Pick two hobbies you are interested in please:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Arts & Crafts | <input type="checkbox"/> Cooking |
| <input type="checkbox"/> Fishing | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Knitting | <input type="checkbox"/> Photography |
| <input type="checkbox"/> Painting | <input type="checkbox"/> Sewing |
| <input type="checkbox"/> Woodworking | <input type="checkbox"/> Other _____ |

Pick three activities you are interested in attending please:

- | | |
|--|--|
| <input type="checkbox"/> Watching Packer games on TV | <input type="checkbox"/> Going to Milwaukee Brewer games |
| <input type="checkbox"/> Going to Mustang (Arena football) games | <input type="checkbox"/> Playing cards |
| <input type="checkbox"/> Playing Billiards | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Playing ping pong | <input type="checkbox"/> Going on picnics |
| <input type="checkbox"/> Playing video games | <input type="checkbox"/> Parties |
| <input type="checkbox"/> Going to Admiral hockey games | <input type="checkbox"/> Attending summer festivals |
| <input type="checkbox"/> Going to see how they make certain products | <input type="checkbox"/> Going to Milwaukee Bucks games |
| <input type="checkbox"/> Going to the movies | <input type="checkbox"/> Going to the Zoo |
| <input type="checkbox"/> Going Bowling | <input type="checkbox"/> Other _____ |

Health History/Physical Activity Questionnaire

Name

Date

Address

City

State

Zip Code

Telephone (Home)

Work

_____/_____/_____
Date of Birth

Code

Although participation in exercise is relatively safe for most apparently healthy individuals, the reaction of the cardiovascular system to increased levels of physical activity cannot always be totally predicted. Consequently, there is a small but real risk of certain changes occurring during exercise participation. Some of these changes may include abnormal blood pressure, irregular heart rhythm, fainting, and in rare cases a heart attack or cardiac arrest. Therefore, it is imperative that you provide honest answers to this questionnaire. Exercise may be contraindicated under some of the conditions listed below; other may simply require special consideration. If any of the conditions apply, consult your physician before you participate in an exercise program.

A. Have you ever had or do you now have any of the following conditions:

- A myocardial infraction
- Coronary artery disease
- Congestive Heart Failure
- Elevated blood lipids (cholesterol and triglycerides)
- Chest pain at rest during exertion
- Shortness of Breath
- An abnormal resting or stress electrocardiogram
- Uneven, irregular or skipped heartbeats (including racing or fluttering heart)
- A blood embolism
- Thrombophlebitis
- Rheumatic heart fever
- Elevated blood pressure
- A stroke
- Diabetes
- Cancer
- A hernia
- Any other heart problem that makes exercise unsafe

B. Do you suffer from any of the following conditions:

- Arthritis, rheumatism or gout
- Chronic low back pain
- Any other joint, bone or muscle problems
- Any respiratory problems
- Obesity (more than 30% overweight)
- Anorexia
- Bulimia
- Mononucleosis

C. Immediate Family History (mother, father, maternal grandmother or grandfather, brothers, sisters, and children)

Has any of the above had:

- _____ Stroke
- _____ Heart Disease
- _____ Cancer
- _____ Tuberculosis
- _____ Kidney Disease
- _____ High Blood Pressure
- _____ Diabetes
- _____ Migraines

D. Do any of the following conditions apply?

- _____ Do you smoke cigarettes?
If yes, how many cigarettes per day? _____
If no, have you ever smoked cigarettes? _____
For how many years? _____
How long ago did you stop smoking? _____

- _____ Do you drink coffee or tea?
If yes, what is your weekly consumption?
- _____ Do you currently drink alcoholic beverages?
If yes, what is your weekly consumption?
- _____ Do you take any prescription medications?

Please list medications:

Medication	For what ailment
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

E. Have you ever had surgery? _____

If yes, please specify:

_____	_____
	Date
_____	_____
	Date
_____	_____
	Date

F. Physical Activity:

Do you engage in regular physical activity? _____

If no, when did you last participate in a regular exercise program?

If yes, please specify below:

Activity	# of sessions per week	Amount of time per session
_____	_____	_____
_____	_____	_____
_____	_____	_____

Age: _____

Gender: Male Female

Ethnic Background:

- _____ American Indian/Alaska Native
- _____ Asian
- _____ Black/African American
- _____ Hispanic/Latino
- _____ Native American/Other Pacific Islander
- _____ White

Highest Level of Education attained:

- Some primary schooling (grades 1-8)
- Completed primary schooling
- Some secondary (High School) Schooling (grades 9-12)
- Secondary School (High School) completed
- Some college or Technical School Training
- College or Technical School Graduate
- Some Graduate School Training
- Graduate School Graduate

Annual Household Income:

- | | |
|---|---|
| <input type="checkbox"/> Less than \$10,000 | <input type="checkbox"/> \$40,000 to \$49,999 |
| <input type="checkbox"/> \$10,000 to \$19,999 | <input type="checkbox"/> \$50,000 to \$74,999 |
| <input type="checkbox"/> \$20,000 to \$29,999 | <input type="checkbox"/> \$75,000 to \$99,999 |
| <input type="checkbox"/> \$30,000 to \$39,999 | <input type="checkbox"/> \$100,000 or greater |

I hereby authorize Dr. _____

and/or _____ to release, disclose and provide the information requested to Our Space, Inc. or any employee, agent or person designated by them. It is my intention by this authorization to comply with any Wisconsin statutes requiring my full and informed consent for otherwise privileged information. A photocopy of this authorization shall be considered as valid as the original.

Client

Date

Witness

Date

Photo Release Form
(Optional)

I _____ give Our Space, Inc. permission to use my
Name

photo and likeness for external release including: newsletters, invitations, mailings

or any other purpose deemed necessary by Our Space, Inc.

Signature

Date

Witness

Date