

MEMBERSHIP APPLICATION



Our Mission

Our mission is to empower adults, experiencing mental illness, achieve their full potential by providing recovery-oriented programs and services in a safe and accepting environment.

Completed applications can be submitted via email to memberapp@ourspaceinc.org, by mail, in-person, or faxed to 414-383-9016.

Incomplete applications will not be accepted.

What Our Space Can Offer You

Our Space provides community living support services to adults to promote stabilization and recovery. Our programs offer occupational therapy, peer support, educational, recreational, and psycho-socialization services. All programs are in response to the expressed needs of the individual and we encourage autonomy among the members we serve.

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
- Receive support through weekly groups

Why should I recommend people to Our Space?

- Our Space provides social, recreational, educational and 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 everyone to express needs and help plan group activities
- Opportunity to become a Board member and set policies on important issues and concerns
- 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

- **Independence-** While criteria for membership is a diagnosis of a mental illness, Our Space is not an adult day care facility and members must be at a level of functioning which requires no staff assistance.
- **Reference-** Prospective members are required to fill out the application in its entirety, which includes a reference from a mental health professional. Reference needs to be signed by a mental health professional such as a case manager, a social worker, a therapist, a psychologist or psychiatrist.
- **Tour-** Prospective members are required to tour the facility as part of the application process. The tour determines if Our Space services are a right fit for them. Please call (414) 383-8921 to schedule a tour and/or indicate tour needed via email when submitting the completed application to memberapp@ourspaceinc.org.
- **Approval-** Upon receipt of a complete application and tour of facility, individuals will be notified of membership approval or denial via phone call, email, and mail within 7-10 business days.

Our Space Membership Application

Name: _____

Address: _____

Street City State Zip

Contact Number: _____ Veteran: Y _____ N _____

Date of Birth: _____ Sex: M _____ F _____ Gender/Identity: M _____ F _____

Ethnicity: White African American American Indian/Alaska Native Asian Hispanic/Latino
 Native Hawaiian/Pacific Islander Bi-racial Other _____

Mental Health Care Provider: _____

Mental Health Care Provider Phone Number: _____

Mental Health Care Provider Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referral Agency/Person: _____

Phone: _____ Email: _____

CCS CSP TCM Other _____

If enrolled in CCS, care coordinator must send CCS referral form and RPOC to bsaenz@ourspaceinc.org upon notification of approval.

Transportation: Bus Van/Care Cab Owner Car Walk Other

Transportation Company name: _____ Phone: _____

Forward ID# _____

Have you toured the facility with an Our Space staff member yet? No ___ Yes ___

If yes, what date did you complete the tour _____

Member Eligibility Reference

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

Name of Reference/Organization

Relationship

Applicant's Signature

Date

Please note, by submitting this document with an electronic signature, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

Information below must be completed by a mental health professional, such as a case manager, social worker, therapist, peer specialist or psychiatrist.

What is this individual's Mental Illness Diagnosis?

Our Space members are not supervised at all times, are voluntary, and are able to leave the facility at any time. Do you have any concerns or foresee any issues regarding this individual's participation in this type of program?

Is there anything Our Space should be aware of regarding this individual's capacity to interact with others in a social setting, any behavioral concerns or triggers?

Any additional information that would be helpful for the staff to know:

Print Name: _____

Signature: _____

Address _____

Phone: _____

Please note, by submitting this document with an electronic signature, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

Thank you for your referral! If you have any questions or additional comments, please contact us at (414) 383-8921.

Our Space, Inc. - 1527 W. National Ave. - Milwaukee, WI 53204 - (414) 383-8921

Rules and Regulations

The following rules are not designed to restrict personal rights and activities, but to ensure that the rights and property of ALL are respected. Failure to adhere to these rules will result in disciplinary action.

1. Smoking allowed in designated area only.
2. Please use appropriate language.
3. No sleeping while participating in Our Space, Inc. Drop-in Center programming.
4. Threats, acts of physical or verbal violence, or abuse, will not be permitted
5. Sexual harassment (verbal or physical) toward staff, or members, is prohibited.
6. Theft of any kind will lead to automatic expulsion.
7. Attending Our Space, Inc. under the influence of alcohol and/or controlled substances is not permitted.
8. No weapons allowed.
9. Please do not harass other members for money, use of cell phones, food, or other items while at Our Space, Inc., or businesses surrounding the facilities.
10. Remain in areas designated for the use of Our Space members. Do not go upstairs unless a group is in session, or prior permission is granted.
11. Please pick up after yourself.
12. Seat belts are required when traveling for activities outside the Our Space, Inc. facilities.
13. Food is only allowed in designated areas.
14. Care must be taken will all furniture and equipment.
15. Please turn cell phones off during groups. If you must keep your phone on, be sure to silence the ringer.
16. Out of consideration for others, please do not take phone calls or listen to music without headphones in the Our Space community room.
17. Out of consideration for the comfort of all members, emotional support animals are not allowed at any Our Space, Inc. Drop-in Center programming.
18. Coffee is available for individuals who are active members of the Our Space, Inc. Drop- In Center programming only.
19. It is the responsibility of the staff to enforce these rules. If you have a concern about the rules, please consult a staff member immediately.

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

Signature: _____ **Date:** _____

General Information

We understand that you may be sensitive about providing the following information. It is, however, essential to help us in maintaining the quality of programming. This information will be kept confidential and personal information and photographs will not be released without your formal written consent (see page 7).

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:

Goals:

- Decrease feelings of depression
- Manage stress/anxiety
- Have a safe and comfortable place to be
- Improve my physical fitness
- Make more productive use of my time
- Feel more calm and peaceful
- Ready myself for future employment
- Connect with others
- Manage my anger in a healthy way
- Cope better with problems
- Learn to stand up for myself
- Improve my social skills/make friends
- Have better control of my emotions
- Feel better about myself
- Improve my social relationships
- Healthy boundary setting
- Other _____

Alcohol and Drugs:

Have you ever had a problem with drugs and/or alcohol? No ___ Yes ___ Do you smoke? No ___ Yes ___
Are you currently using alcohol and/or non-prescription drugs? No ___ Yes ___
If yes, are you interested in obtaining information about alcohol and/or drug treatment? No ___ Yes ___

Mental Health:

Have you ever been hospitalized for mental illness? No ___ Yes ___ 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: _____

Information Release and Disclosure

Please check all that apply

Member's Name: _____ **Date** _____

- I hereby authorize _____, to release, disclose and provide the information requested to Our Space Inc. or any person designated by them. It is my intention by this authorization to comply with Wisconsin statutes requiring my informed consent.

- I give my permission to Our Space Inc. to use my photo and the likeness for external release including: newsletters, invitations, mailings, video, or any other purpose deemed necessary.

- I release Our Space Inc. of any Liability that may occur while I choose to exercise in the Our Space gym. I am giving myself permission to exercise and use the exercise equipment without consulting my doctor.

Member's signature: _____.

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