MEMBERSHIP APPLICATION

Our Mission

Our mission is to empower adults experiencing mental illness to 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 person-centered, strength-based, recovery-oriented services to adults living with severe and persistent mental illness and/or substance abuse issues. Our services provide hope and promote personal growth and healing through one-on-one and peer-facilitated groups, occupational therapy, wellness, and skill-building activities. All programs are in response to the expressedneeds of the individual and we encourage autonomy among the members we serve.

What will I gain from Our Space?

- Create and maintain a network of peers
- Learn skills through participation in educational groups
- Receive support through participation in recovery groups
- Enjoy enriching experiences through community outings
- Gain leadership skills through member management opportunities

Why should I recommend people to Our Space?

- Our Space provides social, recreational, wellness, and educational activities to promote recovery
- Members choose their personal degree of participation and involvement with program activities
- Members are encouraged to express their needs and opinions and help plan groups and activities
- Members can become a member of the Board and set policies on important issues and concerns

Member Process

•**Independence-** Members must be at an independent level of functioning that requires no staff assistance.

•**Reference-** Prospective members are required to complete an application, which includes a reference form from a mental health professional such as a certified peer support specialist, case manager, social worker, therapist, psychologist, or psychiatrist.

•**Tour-** Prospective members are required to tour the facility as part of the application process. We want to ensure that Our Space services are appropriate. Tours are offered Monday – Friday between 9 am and 2 pm. Please provide at least 24 hours advance notice. You may contact reception at (414) 383-8921 to schedule a tour.

•**Approval-** Upon receipt of a complete application and tour of the facility, individuals will be notified of their application status 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____ **Preferred Pronouns:** _____

Ethnicity: ☐ White ☐ Black or African American ☐ Hispanic/Latinx ☐ Asian ☐American Indian or Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Bi-racial ☐ Other_____

☐ CCS* ☐ CSP ☐ TCM ☐ Other _____

***If enrolled in CCS, the care coordinator must submit a CCS referral form and updated RPOC to bsaenz@ourspaceinc.org upon notification of approval.**

Mental Health Care Provider: _____

Mental Health Care Provider Phone Number: _____

Mental Health Care Provider Address: _____

Emergency Contact:_____Relationship:_____Phone: _____

Referral Agency/Person: _____

Phone:_____Email: _____

Transportation: ☐ Bus ☐ Van/Care Cab ☐ Owner Car ☐ Walk ☐ Other

Transportation company name:_____ Phone: _____

ForwardHealth ID# _____

Have you toured the facility with an Our Space staff member yet? No___ Yes ___
If yes, what date did you complete the tour? _____
If no, please contact reception at 414-383-8921 to schedule a tour.

Member Reference

I give Our Space, Inc. permission to contact the below reference regarding 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.

The information below must be completed by a mental health professional, such as a case manager, social worker, peer specialist, therapist, 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 could be activating?

_____

_____

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 agree 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.

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.

1. We are a smoke-free environment. Please smoke outside in the designated area.
2. Please arrive well-rested.
3. Please be respectful of others' personal space and property.
4. Our Space is a recovery-oriented program, therefore alcohol and/or drugs are not allowed. Please do not attend programming under the influence of alcohol and/or drugs.
5. No weapons allowed.
6. Please respect the boundaries of other members.
7. Please pick up after yourself.
8. We ask that you consume any food or snacks in the community room.
9. Please turn cell phones off during groups. If you must keep your phone on, be sure to silence the ringer.
10. Out of consideration for others, please do not take phone calls or listen to music without headphones in the Our Space community room.
11. Out of consideration for the comfort of all members, emotional support animals are not allowed in the Our Space Drop-in Center program.
12. Coffee is available for individuals participating in the Our Space Drop-In Center program.

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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