The Gathering Place
Membership Information

To be Eligible for Membership:

- Have a primary diagnosis of serious mental illness
- Be an active participant in a personal wellness and recovery plan
- Be at least 18 years of age
- Refrain from alcohol/non-prescription drug use
- Not pose a threat to self, others, or the clubhouse community
- All applicants must have a tour of the facility

To Apply for Membership:

1. Call the membership line at 713-275-5338 to schedule a tour.
   Tours are available Monday – Friday between 11 a.m. to 1:30 p.m. by appointment.
2. Submit application.
   Any missing or incomplete components including the referral form and letter of guardianship will unfortunately delay the application process.
3. Application assessed by the review team.
   Please allow the Intake office approximately 1 week to review applications.
4. If application is approved, applicants will be contacted for orientation/start date.
   If application is not approved, applicants will be provided referral sources.

Contact & Additional Information:

Program Coordinator: Shalla Parker
Address: 5310 S. Willow Drive, Houston, Texas 77035
Phone: 713-275-5724 - Press option 2 for membership line
Fax: 713-275-5783
Email: sparker@menninger.edu
Web Address: https://www.menningerclinic.org/treatment/treatment-for-adults/outpatient-programs/the-gathering-place

Hours of Operation: Monday – Friday from 7:30 a.m. to 4:00 p.m.; Closed on holidays
Membership Application
-Please print legibly-

Date of Application: ____________________

☐ New Member  ☐ Returning Member

For Office Use Only
Date Received: ____________________
Entered By: ____________________
Start Date: ____________________

Applicant’s Information

First Name: ____________________ MI: _____ Last Name: ____________________

Address: ________________________________ Apt: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Phone: ________________________________ Email: ____________________

Date of Birth: _____ / _____ / ________ Age: _____________

Please circle all that apply

Place of Birth: USA / Other: ________________________________

Gender: Male / Female / Other: ________________________________

Race: White / Hispanic or Latino or Spanish / Black or African American

American Indian or Alaska Native / Asian / Other: ______________

Primary Language: English / Other: ________________________________

Marital Status: Single / Married / Separated / Divorced / Widowed / Other: __________

Current Living Status: Independently / With Family / Personal Care Home / Other: __________

Medical Alerts

Please circle all that apply

Asthma / Blind or Visual Impairment / Chronic Physical Illness / Deaf or Hearing Impairment
Diabetes  Epilepsy or Seizure Disorder / Hypertension / New Psychiatric Medication / Recent Surgery
Severe Allergic Reactions / Other: __________________________________________
## Guardianship

Do you have a legal guardian? **Yes / No**  **If yes, please provide a letter of guardianship.**  
Guardian Full Name: _____________________________________________________________
Guardian Address: ___________________________________________ Apt: __________
City: _____________________  State: _____________________  Zip: ______________
Guardian Phone: ________________  Guardian Email: ________________________

### Primary Emergency Contact

Full Name: _______________________________  Relationship to you: ____________________
Address: ___________________________________________ Apt: __________
City: _____________________  State: _____________________  Zip: ______________
Phone: ______________________  Email: _______________________________________

### Secondary Emergency Contact

Full Name: _______________________________  Relationship to you: ____________________
Address: ___________________________________________ Apt: __________
City: _____________________  State: _____________________  Zip: ______________
Phone: ______________________  Email: _______________________________________

## Transportation

What is your primary mode of transportation?  

**Please circle all that apply**  
Own vehicle / Metro Bus / Metro Lift / Taxi / Family Member / Transit Center

## Education

**Please circle all that apply**  
Less than High School / Some High School / GED / High School Diploma / Trade School  
Some College / Associate’s Degree / Bachelor’s Degree / Some Graduate Work / Master’s Degree  
Advanced Graduate Degree
Do you have a criminal history? Yes / No

If yes, please provide more information: __________________________________________________________

_____________________________________________________________________________________

What is your veteran status? _________________________________________________________________

What type of insurance do you have? __________________________________________________________

How did you hear about The Gathering Place? __________________________________________________

Do you currently attend another program? Yes / No

If yes, please list the name of the program: ____________________________________________________

Is there anything else you would like for us to know about you?

_____________________________________________________________________________________

_____________________________________________________________________________________

Please print your name and sign below

**Applicant’s** Printed Name: ________________________________________________________________

Signature: ________________________ Date: ______________________

**Guardian/LAR’s** Printed Name: _____________________________________________________________

Signature: ________________________ Date: ______________________
Referral Form
Membership for The Gathering Place
-Please print legibly-

Applicant’s Name: _____________________________________________

All referrals must be made by a Licensed Health Professional and this form must be completed by Referent.

Please circle one
Psychiatrist / Therapist / Primary Care Physician / Licensed Social Worker / Social Worker

Referent’s Name: _____________________________________________
Agency: _______________________________________________________
Address: _______________________________________________________
Phone: _________________________________________________________
Fax: ___________________________________________________________
Email Address: ___________________________________________________

How long have you known this person? _________________________________

Reason for referral to The Gathering Place:
__________________________________________________________________
__________________________________________________________________

DSM-V (Please complete both columns):

<table>
<thead>
<tr>
<th>DSM Codes</th>
<th>List the diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis 1</td>
<td></td>
</tr>
<tr>
<td>Axis 2</td>
<td></td>
</tr>
<tr>
<td>Axis 3</td>
<td></td>
</tr>
<tr>
<td>Axis 4</td>
<td></td>
</tr>
<tr>
<td>Axis 5</td>
<td></td>
</tr>
</tbody>
</table>
Current Medications (Please include dosage):

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Name of Medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>7.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>8.</td>
<td></td>
</tr>
</tbody>
</table>

Does he/she have a history of violent behavior? Yes / No
   If yes, please explain: ________________________________________________

Does he/she have a history of suicide attempts? Yes / No
   If yes, please explain: ________________________________________________

Is he/she currently and/or in the past abused drugs and/or alcohol? Yes / No
   If yes, please explain: ________________________________________________

Has this person been hospitalized in the past 6 months? Yes / No
   If yes, please provide more details: ________________________________

Is there any additional information you would like to add regarding this applicant?
________________________________________________________________________
________________________________________________________________________

Please print your name and sign below

Referent’s Printed Name: ________________________________________________

Signature: ___________________________ Date: ____________________________

This information may be submitted:

In Person-Mail to: The Gathering Place
      5310 South Willow Drive
      Houston, Texas 77035

By Fax: 713-275-5783

By E-mail: sparker@menninger.edu