

OUR SPACE, INC. MEMBERSHIP APPLICATION



Thank you for your interest in Our Space, Inc. Our Space, Inc. provides social, prevocational, recreational, and educational opportunities for members as well as referral assistance with housing, employment, financial and legal matters. In addition, Our Space, Inc. provides members a non-threatening atmosphere where they can come and socialize freely with other members. Please take this time to complete the application. Please return application to:

Our Space, Inc. 1527 W. National Avenue, Milwaukee, WI 53204 Attn.:
Membership Coordinator or fax to 414-383-9016.

We look forward to seeing you at Our Space!

What Our Space Can Offer You

Our Mission is to empower adults who have experienced mental illness to attain a more meaningful life by offering quality programs and services which promote recovery, rehabilitation and renewal. Our Space is based upon a membership and peer support concept, which creates a circle of wellness that enhances connectivity, self-determination and re-integration.

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
- Opportunity to Work in paid pre-vocational positions through the Blue Dove gift shop, Price is Right Shoppe, or janitorial services when positions are available
- 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 are required to fill out the application 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
- Upon receipt of the application and reference letter, individuals will be notified of membership and can begin attending right away
- Potential members are encouraged to tour the facility during the application process to see if the services that we provide at Our Space will work for them

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 TCM CSP Other _____

Transportation: Bus Van/Care Cab Owner Car Walk Other

Transportation Company name: _____ Phone: _____

Forward ID# _____

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

Rules and Regulations for Our Space Members

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.

Smoking in designated area 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 businesses around 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.

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

There is no eating or drinking in designated areas with the exception of water. You may drink water anywhere.

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: _____

Date: _____

Member Eligibility Reference

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

Name of Reference/Organization

Relationship

Applicant's Signature

Date

Must be completed by a mental health professional, such as a case manager, social worker, therapist, or psychiatrist.

Applicant's Name: _____ Date of Birth: _____

What is this individual's Mental Illness Diagnosis?

Our Space members are not supervised at all times, are voluntary and members 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:** _____

Thank you for your referral. If you have any questions or additional comments, please contact our Membership Coordinator at (414) 383-8921 ext. 2.

General Information

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.

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: _____

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

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 Medicare/Medicaid# _____

Activities:

Are you currently involved in any of the following? Our Space Grand Avenue Club DVR Day
Hospital (county) Education Goodwill Industries Curative Rehab M.A.T.C. Milwaukee
Center for Independence Community Support Program

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: _____

Employment:

Are you employed? No Yes If yes: 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

Education: Highest Grade or Level of Education attained in school: _____

Annual Household Income: Less than \$10,000 \$40,000 to \$49,999 \$10,000 to \$19,999 \$50,000 to
\$74,999 \$20,000 to \$29,999 \$75,000 to \$99,999 \$30,000 to \$39,999 \$100,000 or greater

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: _____.