SALLY AND HOWARD
LEVIN CLUBHOUSE

*A program of The Branch*

Dear Potential Clubhouse Colleague,

We're so glad you're interested in learning more about the Clubhouse. A Clubhouse is not a program or a treatment center—it's a community. Our members are adults living with mental health challenges who come together to build meaningful relationships, support one another, and take part in the daily work that keeps our Clubhouse running. **All members work with Clubhouse staff to complete a rehabilitation assessment and goal plan.**

At the Sally & Howard Levin Clubhouse, you'll find:

A place to belong – a supportive community where everyone is valued and respected.

Meaningful work opportunities – members and staff work side by side in areas like clerical tasks, kitchen, reception, outreach, and more.

Employment and education support – help exploring career goals, finding jobs, and continuing your education.

Friendship and connection – opportunities to meet new people, build lasting relationships, and be part of social and recreational activities.

A path of recovery and growth – a place to rediscover strengths, build confidence, and move toward your personal goals.

Most importantly, the Clubhouse is a place where you are needed and wanted. Every member contributes to the life of the community, and together we create something greater than any of us could alone.

We invite you to visit, meet our community, and see for yourself how the Clubhouse can become a meaningful part of your journey.

With warmth and welcome,

*SHLC Colleagues*

| MEMBERSHIP REFERRAL (Updated February 2026) | SALLY AND HOWARD LEVIN CLUBHOUSE A program of The Branch | Sally and Howard Levin Clubhouse A Program of JRS is now The branch Taking inclusion to new heights. |
|---|---|---|

**Directions:** Please return this completed form signed by a **MD, DO, CRNP, PA, MSW, LPC, CRC**, or any other Mastered Level Mental Health Professional (*__*Please Note*__: **Page #4 must be signed by an MD/DO/CRNP/PA/LCSW or LPC per OMHSAS regulations**)
to:
**Mail**: **Sally and Howard Levin Clubhouse 2609 Murray Avenue, Suite #101 Pittsburgh, PA 15217**
**Fax**: (412)-422-9519 /or/ **Email (*preferred*)**: referrals@thebranchpgh.org

## PERSONAL INFORMATION

Date of Referral:_______________________________

Name:_______________________________________________________________________________________________

Address:_____________________________________________________________________________________________

City:______________________________ State: _______________ Zip: _____________ County: ___________________________

Home Phone:__________________ Cell Phone: _______________________Email: _______________________________________

**EMERGENCY CONTACT:________________________________________** Relationship:________________________________

Address:______________________________________________________________________________________________

Home Phone:_________________________ Work Phone:________________________ Cell Phone: __________________________

**REASON FOR REFERRAL_____________________________________________________________________________________**

**__________________________________________________________________________________________________________**

## HEALTH PROVIDERS

Psychiatrist: ________________________________________ Phone:___________________________________________________

Therapist: ________________________________________ Phone:___________________________________________________

Service Coord:________________________________________ Phone:___________________________________________________

PCP: ________________________________________ Phone:___________________________________________________

## HEALTH CONDITIONS

Please list medical problems or disabilities, especially those requiring reasonable accommodations/dietary modification:

______________________________________________________________________________________________________

______________________________________________________________________________________________________

## SOURCE OF INCOME

SSI SSDI VA Job Other:_______________________________________________________________________________

Does applicant have a representative payee? NO YES, specify:___________________________________________________

## INSURANCE INFORMATION

Medical Assistance ID#_______________________________ Medical Assistance Provider:______________________________

Medicare ID# ____________________________________ Medicare Provider: _____________________________________

Private Insurance ID#________________________________ Private Insurance Provider:_____________________________

## CLINICAL INFORMATION

| ICD 10 CODE | DIAGNOSIS |
|---|---|
| | |
| | |
| | |

## ANY INPATIENT PSYCHIATRIC HOSPITALIZATIONS IN THE PAST THREE (3) YEARS? ❑ YES ❑ NO

**If YES, please list hospitalizations below:**

| Facility | From | To |
|---|---|---|
| | | |
| | | |

Has the applicant ever exhibited or made threats of harm to self or others? If so, explain.

_____________________________________________________________________________________________

_____________________________________________________________________________________________

## ANY OUTPATIENT OR PARTIAL HOSPITALIZATIONS IN THE PAST THREE (3) YEARS | ❑ N/A

| Facility | From | To |
|---|---|---|
| | | |
| | | |

## ANY ARRESTS OR INCARCERATIONS IN THE PAST THREE (3) YEARS? ❑ YES ❑ NO

**If YES, please provide details below:**

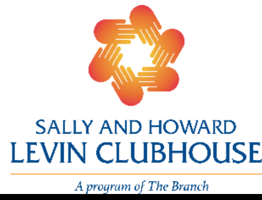
| Date(s) | Details of Arrest/Incarceration<br>(Example: Charges, Probation Information, etc.) | Facility<br>(example: Allegheny Co Jail) |
|---|---|---|
| | ______________________<br>______________________ | |
| | ______________________<br>______________________ | |

Is the applicant currently on parole or probation? If so, please explain above under "details".

## CURRENT MEDICATIONS

| Name | Dose | Frequency | Name | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**If more space is needed for answers, please detail them on a separate sheet, and attach it to the referral.**

| **MEMBERSHIP REFERRAL**<br>**( Updated January 2024)** |  **Sally and Howard Levin Clubhouse**<br>A Program of<br>JRS is now The branch Taking inclusion to new heights. |
|---|---|

## STRENGTHS, SUPPORTS, AND NEEDS ***MUST complete this section in full***

For each area, please rate on a scale of 0 to 5 the level of assistance the applicant needs or desires. Please identify the change that the applicant wishes to make in that domain, if any. Also list their strengths in each of the domains. ***Please note Psychiatric Rehabilitation regulations state that because of mental illness, the individual is considered to have a moderate to severe functional impairment that interferes with or limits performance in at least one of the following domains:*

0 – Needs no assistance    1 – Needs minimal assistance    2 – Needs some assistance

3 – Needs moderate assistance    4 – Needs substantial assistance    5 – Needs extensive assistance

| Scale | Domain | Describe strengths, limitations, and goals in each domain:<br>*(if additional space is needed, please add on to the back of this page, or attach an additional page.)* |
|---|---|---|
| | **Living** | ______________________<br>______________________ |
| | **Learning** | ______________________<br>______________________ |
| | **Working** | ______________________<br>______________________ |
| | **Socializing** | ______________________<br>______________________ |

## REFERRED BY (please print)

Name:______________________________ Title:______________________

Agency:______________________________Phone:______________________

Signature:_________________________ Email:______________________________

## APPLICANT'S SIGNATURE

My signature indicates that this referral has been discussed with me and I agree with it.

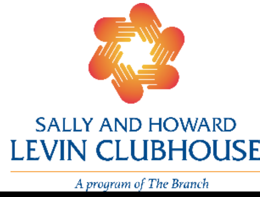
Applicant's Signature:______________________________ Date: ____________________

**REFERRAL CHECKLIST- All applicants will need to provide the following items to be processed in a timely and efficient manner. Please use this checklist to ensure all items are present:**

- ☐ **Completed referral form (this form)**
- ☐ **Signed release of information form**
- ☐ **Signed recommendation from an approved LPHA as outlined on page 4**

# MEMBERSHIP REFERRAL

**(Updated January 2024)**

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***<u>The referral cannot be considered without this signed recommendation.</u>***

**DATE**:____________

TO: **<u>Referral Coordinator, Sally and Howard Levin Clubhouse</u>**

FROM: ______________________________________________________________________________

RE: **<u>Recommendation for Referral to Sally and Howard Levin Clubhouse</u>**

This memo serves as my formal recommendation for ______________________________________________

(Print applicant name)

to receive Psychiatric Rehabilitation services at the Sally and Howard Levin Clubhouse.

_______________________________________________ ________________________________

Printed Name (*Include MD, DO, CRNP, PA, LCSW, LPC, LMFT Designation) Date

_______________________________________________ ________________________________

Signature Date

***__PLEASE NOTE__*** In accordance with Pennsylvania guidelines and regulations for Psychiatric Rehabilitation, this recommendation **MUST be signed by** a "physician or licensed practitioner of the healing arts (LPHA) acting within the scope of professional practice." Persons considered to be **LPHA *includes only the following*:** **Medical Doctors (MD), Doctor of Osteopathic Medicine (DO), Certified Registered Nurse Practitioners (CRNP), Physician Assistants (PA), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC).**

Please contact the Clubhouse Director at (412) 422-1850 for any questions.

## <u>CLUBHOUSE USE ONLY</u>

| ☐ | **Completed referral form (this form)** | | |
|---|---|---|---|
| ☐ | **Signed release of information form** | ☐ | **Signed recommendation from PCP or Psychiatrist (page 4)** |

| **Referral approved by:** | |
|---|---|
| | |
| **Signature** | **Date** |