

GATEWAY CLUBHOUSE

1011 Schaub Dr, Suite 200, Raleigh NC, 27606

919-662-0940 or 919-231-3325 info@nc-cws.org

Intake Application

Service Area and Program Interest

What program is the individual interested in? Clubhouse Gateway to Work
 Gateway Community Support TBI Waiver Services

Information About Person Needing Services

Full Name: _____ Primary Phone: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Emergency Contact: _____ Phone Number: _____

Date of Birth: _____ last 4 digits Social Security No.: _____

Gender: _____

Who referred you to Gateway? _____ Affiliation: _____

Phone Number: _____

Has the individual served in the military? YES NO

Brain Injury Information

Date of Brain Injury: _____

How was brain injury acquired? Motor Vehicle Accident Blow to head Stroke Assault

Gunshot Wound Aneurysm Infection Tumor Fall

Other (Please describe) _____

Please provide a few details about your brain injury: _____

Lost consciousness? YES NO Unknown

If yes, length of coma? Less than 24 hours 24-48 hours More than 48 hours Unknown

Medical Information

Describe medical/health problems not related to brain injury including diagnosis and current treatment

Is there a history of seizures? YES NO Unknown

Date of last seizure: _____

Please describe seizures: _____

Primary Care Physician: _____ Phone Number: _____

Neurologist: _____ Phone Number: _____

Other doctors or medical providers? _____

Pharmacy Name: _____ Phone Number: _____

Current Medications

Medication Name	Dosage	Frequency	Reason

Health Insurance

Currently insured? YES NO Unknown Medicaid Medicare Private/Other Unknown

Legal Information

Do you have a legal representative? YES NO Unknown Type of Legal Representative: _____

Name: _____ Relationship: _____ Phone Number: _____

Services

Has the individual needing services ever had any of the following?

History of substance or alcohol abuse? YES NO UNKNOWN

If Yes, is individual actively involved in a treatment program? YES NO UNKNOWN

If Yes, has individual completed a treatment program? YES NO UNKNOWN

When was the last time substance or alcohol was used? _____

Does the individual currently receive counseling, psychological, or psychiatric services?

YES NO UNKNOWN

If yes, please describe diagnoses and current treatment: _____

Please describe any additional mental health history not noted above: _____

Has the individual ever been arrested or convicted of a crime? YES NO UNKNOWN

Criminal History does NOT exclude an individual from services

If yes, please describe criminal history: _____

Please describe current involvement with judicial system (if any): _____

Employment Services

Currently employed? YES NO

Employer: _____ Job Title: _____

Currently working with VR services through DARS? YES NO

If yes, VR Counselor Name: _____

Currently working with a job coach? YES NO

If yes, job coach name: _____

Service Needs Assessment

Please rate the abilities of the individual needing services. Use the rating scale below to check the appropriate box.

1 Needs total help	2 Needs significant help	3 Needs some help and supervision	4 Can complete but needs supervision	5 Fully independent, no help needed
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Financial planning and paying bills 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Time Management 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Decision Making 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Housekeeping (household chores, errands) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Movement 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Using and Arranging Transportation 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Speech, Language, Communication 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Self-Care (bathing, dressing, etc) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Learning New Skills 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>

Please check the services for which assistance is needed.

- | | | |
|---|---|--|
| <input type="checkbox"/> Brain Injury Education | <input type="checkbox"/> Finding a Place to Live | <input type="checkbox"/> Social and Recreational Opportunities |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Home skills | <input type="checkbox"/> Finding or Keeping a Job |
| <input type="checkbox"/> Problem Solving Mental | <input type="checkbox"/> Health Services Social Skills | <input type="checkbox"/> Medical Appointments and Referrals |
| <input type="checkbox"/> Budgeting and Money Management | <input type="checkbox"/> Applying for Benefits | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Volunteer Opportunities | <input type="checkbox"/> Increasing Productive Activity | <input type="checkbox"/> Coping with memory difficulty |
| <input type="checkbox"/> Acquiring Assistive | <input type="checkbox"/> Technology | <input type="checkbox"/> Anger Management |
| <input type="checkbox"/> Impulse Control | <input type="checkbox"/> Homeless Service | |

Please return this Intake Application to:

Gateway Clubhouse, 1011 Schaub Dr. Suite 200, Raleigh NC, 27606

Unless otherwise instructed by staff

This application may also be faxed to the Brain Injury Support Director at 919 231-9189 or

info@nc-cws.org