Dear Prospective Member:

Thank you for your interest in becoming a member of Breakthrough. This is the application packet that must be completed.

- **Application for Services:** Prospective member completes
- **Eligibility Determination Form:** Psychiatrist/Therapist/Family Doctor completes

Please return the application packet to **Heather Snapp:**

Mailing address:  
**Breakthrough**  
P.O. Box 670  
Wichita, KS 67201

Fax:  
(316) 262-8882

Physical address:  
**1010 N. Main (9th and Main, 2 story off white building)**

Once we have received the Application for Services and the Breakthrough Eligibility Determination Form, we will assess your eligibility for membership. If you are eligible, we will call to set up a time for enrollment. If you are not eligible, we will mail a letter explaining why. If your address or phone number changes, please let us know so we can maintain contact with you.

If you have any questions, please call **Heather Snapp at 269-2534, ext. 110 or email heather.snapp@esswichita.org**
BREAKTHROUGH

Application for Services

Name: _______________________________________________________________
   First   Last   MI   Maiden (if applicable)

Address: ___________________________________________ City: _____________

Zip Code: _____________ Home Phone: (_____) __________________________

Cell Phone: (_____) ___________ Email: ____________________________

Age: _______ Date of Birth: ___________ Race: ____________________

Marital Status: ___________   Gender:   Male   Female

REASON FOR REFERRAL

What support services are you interested in?

☐ Employment    ☐ Wellness    ☐ Payee Services
☐ Education     ☐ Social Activities

EMPLOYMENT

Are you currently working?      Yes    No
If not, are you interested in working?    Yes    No
Are you currently receiving Vocational Rehabilitation Services?     Yes    No
If yes, who is your VR Counselor?______________________________
Are you currently receiving employment services through another agency?
    Yes    No

EDUCATION

Please list your last grade completed: ____________________________
REFERAL SOURCE (Circle one):
☐ Alcohol/Drug Program  ☐ Breakthrough Website  ☐ COMCARE
☐ Facebook/Twitter  ☐ Family/Friend  ☐ MHA
☐ Private Doctor/Therapist  ☐ Self  ☐ VA
☐ Vocational Rehabilitation Services  ☐ Other_______________________

Referral Name:_________________________ Phone: (____)__________________
Address:___________________________________ Zip Code:________________

EMERGENCY CONTACT INFORMATION
Legal Guardian:________________________ Relationship:________________
Address:___________________________________ City:________________
Zip Code:________________ Phone: (____)__________________
Cell Phone:__________________ Email:________________________________

Emergency Contact/Relative:__________________ Relationship:___________
Address:___________________________________ City:________________
Zip Code:________________ Phone: (____)__________________
Cell Phone:__________________ Email:________________________________

Case Manager? Yes No Name:_________________________________
Agency:______________________________ Phone:______________________
Cell Phone:__________________ Email:________________________________

PHYSICAL/MENTAL HEALTH
Do you smoke? Yes No
Do you receive Medicaid? Yes No
List any medical/physical health problems:____________________________________
________________________________________________________________________
________________________________________________________________________
Physician:______________________________________________________________
Psychiatrist/Agency:_____________________________________________________
Therapist/Agency:_______________________________________________________

LEGAL
Do you have any legal problems or past convictions? Yes No
If yes, please explain:_____________________________________________________
_______________________________________________________________________
Probation/Parole Officer:________________________ Phone:__________________
Dear Prospective Member:

This is the part of the application process that your Psychiatrist or Therapist or Family Doctor needs to complete and return to us.

- Breakthrough Eligibility Determination Form

Mailing Address:   Breakthrough Club
ATTN:  Heather Snapp
P.O. Box 670
Wichita, KS. 67201

Fax:       316-262-8882

Physical address:
1010 N. Main (the corner of Main and 9th)

If you have any question, please feel free to call Heather Snapp at 269-2534 ext. 110, or email heather.snapp@esswichita.org
Breakthrough Club
Eligibility Determination Form
(to be completed by Psychiatrist, Therapist, or Family Doctor)

Consumer Name ____________________________ Date __________

Address __________________________________ Zip Code ______________

Phone ______________________ DOB ________ Social Security # ______________________________

Diagnosis and DSM V Code:

Primary __________________________________________________________

________________________________________________

________________________________________________

1. □ Yes □ No Borderline Intellectual Functioning
2. □ Yes □ No Mental Retardation
3. □ Yes □ No Traumatic Brain Injury

If yes to #1, #2, or #3 what level of functioning:

□ Needs 1:1 support □ Unable to tolerate noise/activity/commotion
□ Anger outbursts in response to environment or interactions w/ others
□ Does well in groups w/ minimal supervision □ Other: ________________________________

4. Please review each of the following and check any that apply.

□ History of violent behavior, □ Person felony conviction, □ Arrested for physical violence toward others,
□ Verbal harassment of others, □ Anger outbursts, □ Destruction of property, □ Stalking behavior
□ Other: ________________________________
□ None

Name of Physician/Therapist (please print): ________________________________

Agency/Office Name ____________________________ Phone ____________________________