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 USE ONLY:
CONSUMER MEETS ADMISSION CRITERIA: YES NO

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