Choices, A Community Social Center, Inc.
320 E. South St., Akron, OH, 44311
Tel: (330) 762-8151 Fax: (330) 762-5041
www.choicesakr.com/choicesakr@sbcglobal.net

Membership Application

(Must be at least 18 years of age to apply)

Choices Mission

The mission of Choices is to provide a community-based recovery-oriented center for adult mental health consumers receiving treatment for a serious, persistent mental illness in Summit County.

Criteria for Membership

Members must be an adult (18 years of age or older) and be receiving mental health services for a serious, persistent mental illness in the Summit County area.

Name: _____ Date: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Phone _____
(HOME) (WORK) (OTHER)

Birth Date: ____/ ____/ ____ (Age verification required of members and guests at Choices)

How did you hear about CHOICES?_____

Choices may use this information to contact you in the event of an emergency or other situation, but will never share this information with other persons or agencies. Choices may print your name or image in Choices' newsletter or other medium for purpose of recognition, e.g., birthday, congratulations.

Please indicate your mental health provider;
(letter of reference must be completed and faxed by your provider to Choices within 30 days)

Name: _____ Title: _____

Person to contact in case of an emergency;

Name: _____ Phone: _____

Address: _____

Please provide the following optional information to Choices for use in an emergency.

Enter any health problems Choices needs to know about; (ex: diabetes, epilepsy, heart condition etc.)

_____

Enter any allergies, including food allergies; (ex: cats, perfume, peanuts, etc.)

_____

_____

The following information is to be used for statistical reporting only.

African-American:	☐	Caucasian:	☐	Native American:	☐
Asian/Pacific Islander:	☐	Hispanic:	☐	Multi-Racial:	☐

Are you a veteran? Y / N **Do you have any record of arrest?** Y / N

To become a member of Choices you must read, or have someone read to you, and follow Choices' Orientation Manual including the Code of Conduct. Choices' Code of Conduct is meant to ensure that the center is a pleasant and safe place for everyone. Violations of the Code of Conduct may result in suspension or removal of your membership privileges. You are expected to read the complete Orientation Manual packet and all Choices client rights procedures and refer to them as needed. They will also be reviewed during orientation.

By signing below, I declare that I have read, received and understand Choices' Orientation Manual. Choices abides by the "HIPPA Privacy Rule." We are required to protect the privacy of your protected health information – health information that identifies you. These rights are shared by all Choices members. Please do not repeat to others what you hear at the Center, especially in all closed recovery-oriented groups such as DRA, Peer Support Group, etc.

Name: _____ Date: ____/____/____

Witness: _____

Office Use Only

Referral letter received	Y / N _____	Date of application	/ / _____
Age verification received	Y / N _____	Membership Expires	/ / _____
Membership orientation	/ / _____		