Myrt Armstrong Recovery Center
Membership Packet

Name _____ Birthdate _____ Today's Date _____

Address _____City _____ Phone _____

Gender: __ Male __Female __ Other/mixed Income: __under $500/Mo __$501-$999/Mo __ $1000+/Mo.

Race (optional): __Native American __African American __ Asian/Pacific __White __Hispanic __Other

Medical Information/Allergies _____

Are you being treated for a mental illness? **Y / N**

Service Provider Name_____ **N/A**

Agency _____ Phone _____

If N/A, are you interested in exploring service options? **Y / N**

Emergency Contact

Name _____ Number_____ City/State _____

Problems with illegal drugs or alcohol? **Y / N** Explain _____

Have you been hospitalized in the last 6 months for mental illness? **Y / N** Where? _____

Do you have a friend or family support system outside the MARC? **Y / N**

Sign to indicate you received an explanation

Release of Information explained _____
Referral process explained _____
Club guidelines, member expectations explained _____
Confidentiality explained _____

I have answered all of the above questions truthfully. I understand that false statements may be grounds for termination of membership.

I understand that I am responsible to helping maintain the safe and supportive environment outlined by the mission of the MARC. I agree to keep my words and actions positive when at the MARC.

I understand that choosing not to follow these expectations may lead to disciplinary action up to and including termination of membership at the MARC.

I understand that exceeding these expectations will make me eligible for "Above and Beyond" certificates, recognitions, and rewards.

Signature _____ Date _____

Director Signature _____ Date _____

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Referral Form

In regard to _____ Date _____

QMHP opinion

It is my professional opinion, as a Qualified Mental Health Professional as defined in North Dakota Code 25-03.2-01*, that the above named individual meets the definition of a person with a mental illness as defined in North Dakota Code 25-03.1-02**.

Diagnosis:

Axis I _____ DSM Code _____

_____ DSM Code _____

Axis II _____ DSM Code _____

Acknowledgment (To be completed by QMHP)

Signature _____ Printed name _____

Qualifications _____ Agency _____

City/State _____ Phone _____ Date _____

Non-QMHP opinion

It is my belief that the above named individual suffers from a mental illness as defined in North Dakota Code 25-03.1-02**. These are the reasons I believe such. _____

_____

_____

Signature _____ Printed Name _____

Agency _____ Title _____

City/State _____ Phone _____ Date _____

*"Qualified mental health professional" means a licensed physician who is a psychiatrist, a licensed clinical psychologist who is qualified for listing on the national register of health service providers in psychology, a licensed certified social worker who is a board-certified diplomate in clinical social work, or a nurse who holds advanced licensure in psychiatric nursing.
**"Mentally ill person" means an individual with an organic, mental, or emotional disorder which substantially impairs the capacity to use self-control, judgment, and discretion in the conduct of personal affairs and social relations. "Mentally ill person" does not include a mentally retarded person of significantly subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior, although a person who is mentally retarded may also suffer from a mental illness. Chemical dependency does not per se constitute mental illness, although persons suffering from that condition may also be suffering from mental illness.