Richmond Wellbeing

FELLOWSHIP HOUSE MEMBERSHIP FORM

FELLOWSHIP HOUSE MEMBERSHIP FORM

Our Albany based Community Resource Centre, Fellowship House, is here to support you with access to a range of learning opportunities, social connection supports, and family carer services. Located close to the Albany CBD, Fellowship House is a place for anyone dealing with mental health distress to feel welcome, respected and believed in.

To access Fellowship House, and to process this application, we need permission to contact your clinical support and emergency contact. Please complete the attached referral form and the consent to store and release information form with the relevant details.

For further information please visit our website www.rw.org.au, contact us on 1800 742 466, or email our Intake Officer at intake@rw.org.au

FELLOWSHIP HOUSE MEMBERSHIP FORM

REFERRER DETAILS

Name _____ Agency/Position _____

Postal Address _____ Postcode _____

Phone _____ Email _____

How did you hear about us?

- ◯ Website
- ◯ Friend/Family/Another client
- ◯ Flyer
- ◯ Social Media
- ◯ Radio
- ◯ Advertising
- ◯ Event
- ◯ Google
- ◯ Other _____

Applicant to Complete

First Name _____ Family Name _____

Preferred Name _____ Date of Birth _____

Address _____ Postcode _____

Phone _____ Mobile _____ Email _____

Gender:

- ◯ Female
- ◯ Transgender Female (MTF)
- ◯ Male
- ◯ Prefer not to disclose
- ◯ Different Identity (please state) _____
- ◯ Transgender Male (FTM)
- ◯ Non Binary
- ◯ Self describe

Sexuality:

- ◯ Straight/Heterosexual
- ◯ Lesbian/Gay/Homosexual
- ◯ Bisexual
- ◯ Unsure
- ◯ Self describe _____
- ◯ Prefer not to disclose

Intersex Status:

- ◯ Yes
- ◯ No
- ◯ Unsure

FELLOWSHIP HOUSE MEMBERSHIP FORM

APPLICANT TO COMPLETE (continued)

Pronouns:
- ◯ They/Them/Theirs
- ◯ She/Her/Hers
- ◯ He/ Him/His
- ◯ None/My Name
- ◯ Other _____

Relationship Status:
- ◯ Single
- ◯ Married
- ◯ Separated
- ◯ Self Describe _____
- ◯ Divorced
- ◯ Widowed
- ◯ Defacto

Aboriginal ◯ Yes ◯ No Torres Straight origin ◯ Yes ◯ No

Country of Birth _____ Culturally & Linguistically Diverse ◯ Yes ◯ No

Main Language spoken ◯ English ◯ Other Other _____

Interpreter required ◯ Yes ◯ No Children ◯ Yes ◯ No

Occupation _____

Source of income:
- ☐ Age Pension
- ☐ Carer Allowance
- ☐ Disability Pension
- ☐ Department of Veteran's Affairs
- ☐ Unemployment (Newstart)
- ☐ Youth Allowance
- ☐ Paid Work
- ☐ Other _____

Living
- ◯ Living Independently
- ◯ Living with family member/carer
- ◯ Other _____

Hold a DVA Card? ◯ Yes ◯ No

If yes, what type? ◯ Gold ◯ White ◯ Other

FELLOWSHIP HOUSE MEMBERSHIP FORM

APPLICANT TO COMPLETE (continued)

Allergies or medical conditions

Emergency Contact

Name | Phone Number

Current Supports (Organisation and Individuals)

Name	Phone	Type of support
Name	Phone	Type of support
Name	Phone	Type of support
Name	Phone	Type of support

FELLOWSHIP HOUSE MEMBERSHIP FORM

ABOUT YOUR RECOVERY

Please indicate how you feel

- ◯ I don't know what recovery is.
- ◯ I am starting to think about my recovery.
- ◯ I am actively taking steps towards recovery.
- ◯ I am achieving my goals but still have more to do.
- ◯ I have achieved my goals. I live the best life possible.

How would you describe your mental health experience?

What are your strengths and/or passions?

What are you hoping to gain from Fellowship House?

What do you feel you need to do, know or learn to enhance your recovery?

FELLOWSHIP HOUSE MEMBERSHIP FORM

CONSENT

I acknowledge the information provided is true and correct.
I consent to the disclosing of my personal and health information to Richmond Wellbeing for the purpose of assessing my eligibility for receiving recovery support services.

Name of consenting applicant

Date

Please complete form and return to Richmond Wellbeing
E: intake@rw.org.au