



176 Walker Street, 2nd Floor, Lowell, MA 01854
♦ Fax: (978) 937-7867 ♦ Email: hgilbert@eliotchs.org ♦

A Clubhouse Program of Eliot Community
Human Services, Inc.

Renaissance Club Recommendation

Renaissance Club is a program of Eliot Community Human Services, Inc. for individuals recovering from mental illness. Our philosophy and operating premise is that people living with mental illnesses can have jobs that they like, live independently, sustain positive relationships with others, and lead productive lives in the community. The club operates as a joint effort between our staff of nine and our membership of about one hundred and fifty. New members are always welcome. Please complete the enclosed documentation and call Heather Gilbert at (978) 454-7944 to schedule a visit and tour of the clubhouse. It is our intention to help members realize that they are welcome and wanted.

The clubhouse accepts adults (18 years and older) with a primary diagnosis of mental illness. Prospective members are encouraged to complete an orientation period to learn about all areas of the clubhouse, the various work units, employment opportunities in the community, education and social programs, as well as transportation accessibility. A goal at our clubhouse is to help members increase their independence and an assumption is that each person takes responsibility for his/her own diet, medication, and safety. We are substance and alcohol free.

The Renaissance Club philosophy is based on a belief that everyone wants to work and be a part of a community. We encourage a business-like atmosphere and a focus on work in the clubhouse.

*A place to belong
A place to return
The opportunity to develop meaningful relationships
And the opportunity for meaningful work*

Name: Gender/Preferred Pronouns:
 Address: DOB:
 Phone: SSN:
 Email: Language preference:

Physical Limitations (please circle):		
Blind, Total Loss of Vision	Hearing Impaired	Semi-Ambulatory, Cane
Legally Blind (<20/200)	Medical Condition, Serious/Chronic	Other Impairment, Not Listed
Deaf, Severe to Profound	Non-Ambulatory, Wheelchair	None or Unknown
Please list any other medical conditions, allergies, or disabilities:		

Psychiatric Diagnoses:			
Date of Diagnosis:		Diagnosing Clinician:	
DSM Code:		Diagnosis:	
(list for each)		(list for each)	

Assess Current Potential for the following (check appropriate box):				
	No potential	Minimal	Moderate	High
Assaultive Behavior				
Self-destructive Behavior				
Alcohol Misuse/Abuse				
Drug Misuse/Abuse				
Property Damage				
Domestic Violence				

Additional Information:					
Referring Clinician:		Agency:		Phone #:	
Physician:		Agency:		Phone #:	
Therapist:		Agency:		Phone #:	
Mass Health Claim #:		Medicare Claim #:			
*Emergency Contact:		Address:		Phone #:	