PASS PROGRAM APPLICATION- 2018

Prevention, Access, Self-Empowerment and Support

MAIL OR FAX APPLICATION by May 14th, 2018

ADDRESS: CCSI – PASS Program
1099 Jay Street, Bldg.-J, 3rd Floor
Rochester, NY, 14611.

FAX: (585) 328-5211
Attn: PASS Program – Neville Morris

CONTACT INFORMATION

Program Manager:
Neville Morris MBA
Phone: (585) 690 - 6260 work
Phone: (607) 765 – 5656 cell
Email: NMorris@CCSI.org

Additional Information:

- **Reach out to the Program manager**
- **Visit the website at CCSI.ORG, Programs, PASS Program**
  - **Graduate parent and adolescent perspectives.**
  - **Program objectives, awards etc.**



P.A.S.S. PROGRAM 2018 APPLICATION

(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

PARENT, GUARDIAN, PRIMARY CARE GIVER – SECTION 1

Form - Must be completed by: Parent, Guardian, Primary Care Giver etc.

*Please print or type

PARENT OR GUARDIAN INFORMATION:

Name_____
(last) (middle) (first)

Address_____

_____ _____ _____
City State Zip

Primary Phone (_____) _____ (Please Circle Primary: Home, Cell, Work)

Phone (_____) _____ (Home) Best time to call: _____

Phone (_____) _____ (Cell) Best time to call: _____

Phone (_____) _____ (Work) Best time to call: _____

Email address _____

Relationship to Applicant _____

OTHER PARENT/GUARDIAN:

Name_____
(last) (middle initial) (first)

Address_____

_____ Email: _____

Primary Phone (_____) _____ (Please Circle Primary: Home, Cell, Work)

Phone (_____) _____ (Home) Best time to call: _____

Phone (_____) _____ (Cell) Best time to call: _____

Phone (_____) _____ (Work) Best time to call: _____

Email Address _____

Relationship to applicant _____

P.A.S.S. Applicant: _____ Confidential Information

Does applicant have a parent or a relative with a mental health challenge? ☐ Yes ☐ No

With whom does adolescent/applicant reside? NAME_____

Organization:_____ Phone: _____

☐ Mother ☐ Father ☐ Both ☐ Other- please specify:

_____

Does applicant have any siblings who currently reside at the same address? If yes, please provide us with their names, age and sex.

NAME	AGE	SEX

Does your child smoke cigarettes? ☐ Yes ☐ No

Does your child have permission from you to smoke cigarettes? ☐ Yes ☐ No

If yes, please be advised that your child will not be allowed to smoke in the sleeping rooms or any rooms related to P.A.S.S. events.

Your child must agree to stay in the non-smoking room provided and adhere to the hotel's requirements where smoking is concerned.

Are you supportive of applicant's participation in this program? ☐ Yes ☐ No

Please explain:

_____

_____

Is there an IEP or 504 Plan in place for the applicant? _____

Please describe accommodations or supports currently being provided:

_____

_____

Additional information on applicant or any concerns you may have as

P.A.S.S. Applicant: _____ Confidential Information

_____

_____

P.A.S.S. PROGRAM - WORKSHOPS 2018			
	WHEN	**WHO**	**WHERE**
Workshop #P	**July 13th - 15th Friday – Sunday Noon**	**Parents/Guardians**	**Grand Island, NY**
Workshop #1	**Aug 23rd – 26th Thursday – Sunday Noon**	**Adolescents**	**Grand Island, NY**
Workshop #2	**October 11th – 14th Thursday – Sunday Noon**	**Adolescents**	**Grand Island, NY**
Workshop #3	**December 6th – 9th Thursday- Sunday Noon**	**Adolescents**	**Rochester, NY**
Graduation	**December 8th 6:00pm Saturday**	**Parents, Guardians, Family & Friends**	**Rochester, NY**

***All parents of selected applicants are expected to attend the Parent & Mentor Training and Orientation Workshop in July (Parents and Guardians only.)**
***Transportation, lodging and food will be provided for the Parent & Mentor Training and Orientation Workshop.**
***Please begin to make tentative arrangements – i.e. Time off work if applicable, and Daycare arrangements, etc. to attend.**
***Selected applicants usually do much better when parents attend this workshop and also take an integral role in the adolescent's participation in the program.**
Please submit (mail or fax) completed application by Monday May 14th 2018.
MAIL or FAX APPLICATION **Coordinated Care Services Inc.** **Cultural Competency & Diversity Initiatives** **Attn: PASS Application & Recruitment** **1099 Jay St. Building J, 3rd Floor, Rochester, NY 14611** **or** **FAX: (585) 328-5211**
CONTACT: **Neville Morris at (585) 690-6260 work, (607) 765-5656 cell, Email: Nmorris@ccsi.org**

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P.A.S.S. PROGRAM

(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

LUGGAGE CHECK
Form – Must be completed by: PARENT, GUARDIAN/PRIMARY CARE GIVER, etc.
*Please print or type

The P.A.S.S. Program makes every effort to provide a safe and drug free environment for all participating adolescents, mentors, staff, consultants, and guests.

Parent Note:

Please ensure that your child's luggage is free from illegal substances and/or weapons. This procedure ensures the safety of all involved with the P.A.S.S. Program.

Parents please read carefully and sign below. Your child will not be permitted to attend any P.A.S.S. related events without the receipt of this signed document/form.

5

I _____ ensure that _____ luggage
Parent Name (please print) Adolescent

has been searched by me (parent/guardian). He/She is free from any illegal substances and/or weapons being carried to the bus and to the hotel.

_____ _____
Parent Signature Date

Note:

Parents, this form must be completed and collected for the application and at the time of pick up for each P.A.S.S. related events (Adolescent Workshops). It will be included in all correspondence pertaining to upcoming workshops. If this form is not signed and received at pick up, your child will not be able to board the bus.

P.A.S.S. PROGRAM

(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

PERMISSION TO REQUEST INFORMATION

Form - Must be completed by: PARENT, GUARDIAN/PRIMARY CARE GIVER, etc.

*Please print or type

Please complete the permission form below and give it to the appropriate institution along with the Information Request Form. Some of the information requested, both from your child's mental health professional and school, is considered confidential and permission is needed before it can be shared with P.A.S.S.

I _____
Parent/Guardian name

give permission to:_____
Name of school / organization

Mental health professional: _____

to share information about _____
Applicant name

to the Coordinator of the P.A.S.S Program. This information is needed so my child can be considered for participation in the program.

_____ _____
Parent/Guardian Signature Date

P.A.S.S. PROGRAM 2018

(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

MEDICAL AGREEMENT

Form - Must be completed by: PARENT, GUARDIAN/PRIMARY CARE GIVER, etc.

*Please print or type

Adolescent Name: _____ Date of Birth: _____

I/We being the parent/guardian of the above youth, _____do _____do not appoint the P.A.S.S. PROGRAM to act on our behalf in authorizing emergency or otherwise necessary medical, dental, surgical care and hospitalization for the above named youth.

I/We understand that we will be notified in advance of the specific times, dates and chaperones/mentors for events as they are scheduled and will be requested to sign permission slips for each such event.

I understand that in some instances travel to another community may be a part of the P.A.S.S. program.

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I agree to have my child included in these activities _____yes _____no

Signature of Parent/Guardian _____Date: _____

Address: _____

Home Phone #_____ Work Phone #: _____

Emergency Contact Name: _____ Phone # ( ) _____

Hospitalization Coverage for the applicant:

**Please complete Hospitalization Coverage Information on the next page*

Hospitalization Coverage for the applicant:

Insurance Co. or other Program: _____

ID or Contract #_____

Family Physician Name_____ Phone # _____

Please describe any specific illness that applicant is experiencing. If necessary, please attach special instructions for applicable illness (e.g. if child is diabetic):

_____

_____

_____

_____

_____ 8

_____
Parent(s)/Guardian Signature

_____
Date

THIS FORM WILL BE RETAINED BY EVENT SUPERVISOR
AND WILL ACCOMPANY THE ADOLESCENT ON EACH WORKSHOP TRIP.

P.A.S.S. PROGRAM

(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

TRANSPORTATION AGREEMENT
Form - Must be completed by: PARENT, GUARDIAN/PRIMARY CARE GIVER, etc.
*Please print or type

Adolescent Name: _____

As parent/guardian of the above youth, I hereby consent to participation by my child in the P.A.S.S. sponsored workshops.

I understand that in some instances travel to ANOTHER COMMUNITY may be a part of the P.A.S.S. program.

I agree to have my child included in these activities _____yes _____no

Based on your location, I understand that this activity will involve my child traveling by either:

_____plane _____car _____bus _____train

I understand that my child may share a hotel/motel room with another child of the same sex.

I understand that my child will be under the supervision of the P.A.S.S. PROGRAM. While at this event, my child is subject to all rules and regulations with respect to the P.A.S.S. PROGRAM.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date:_____

Home Phone #_____Work/Emergency Phone #_____

Transportation is provided for applicants selected for the program by PASS designated representatives or vendors. Please provide us with the following information for use in making travel arrangements:

Residence/where adolescent will be picked up:

Contact Person: _____ Phone:_____

*Transportation Agreement: continued on Next Page

P.A.S.S. PROGRAM

(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

FAMILY AGREEMENT

Form - Must be completed by: PARENT, GUARDIAN/PRIMARY CARE GIVER, etc.
*Please print or type

I accept _____ as a CHAPERONE/MENTOR for my child in the P.A.S.S. PROGRAM. The Coordinator of the P.A.S.S. PROGRAM has given me a copy of the Guidelines for Family, Youth and Chaperones/Mentors and discussed them with me. I understand them and agree to abide by them. I understand that the CHAPERONE/MENTOR is a non-professional volunteer.

I have listed here any information or concerns about my child, such as activities to do or avoid allergies, dietary limitations, fears likes/dislikes, medications, and any other special needs:

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Allergies: _____No _____Yes -**If yes, please specify and print below*:

Specify: _____

_____

Requires a Special Diet: No _____Yes -**If yes, please specify and print below*:

Specify: _____

_____

**Family Agreement: continued on Next Page*

Takes Medications: No _____Yes _____ -**If yes, please specify and print below*:

Specify: _____

_____

Can your child administer his/her own medication? No_____ Yes_____

What is the dosage of the medication he/she is taking? _____

_____

When is the medication taken? _____

Activities to avoid: _____

Fears: _____

Likes: _____

Dislikes: _____

Special Needs: _____

_____

Emergency Contact: _____Phone # _____

Relationship to my child: _____

Hospitalization Coverage for the above-named youth:

Insurance Co. or another Program: _____

ID or Contract #_____

Family Physician Name: _____Phone #_____

Primary Care Physician: _____ Phone # _____

Signature of Parent/Guardian_____Date:_____

P.A.S.S. PROGRAM
(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

MEDIA RELEASE AGREEMENT

Form - Must be completed by: ADOLESCENT and PARENT, GUARDIAN/PRIMARY CARE GIVER, etc.
*Please print or type

From time to time adolescents are in media (photo, video, etc.) taken at P.A.S.S. events. These Medias are sometimes used in conjunction with the P.A.S.S. project, in a published format, overheads, pamphlets, flyers, etc. At no time will Medias or names be used for sale; gains of profit or in any derogative manner i.e. to ridicule, scandal, reproach, scorn or in dignify adolescents. P.A.S.S. hereby requests the right and your permission to copyright and/or use, reuse and/or publish, and republish Medias in which the media may sometimes be distorted in character, or form, in conjunction with their own or a fictitious name, on reproductions thereof in color, or black and white made through any media by an assigned P.A.S.S. Affiliate, for any purpose whatsoever; including the use of any printed matter in conjunction therewith.

I waive the right to inspect to approve the finished format-Medias - photograph, video, or advertising copy or printed matter that may be used in conjunction with the P.A.S.S. Program. I grant the P.A.S.S. Program the following rights in the use of my child's likeness, voice or materials supplied by me or P.A.S.S. assigned Affiliate, in a production to be produced by P.A.S.S. P.A.S.S. will have total ownership of the production and material submitted, the right to edit the production and materials, the right to broadcast the production and materials; may use my name or my child's, likeness, appearance, voice, biological information and the material supplied by me or my child for purposes of advertising, publicity and/or sales promotion. P.A.S.S. retains the rights to all materials provided or produced (as described above), and the use of these materials will not violate the rights of any person or organization and will not incur any liability for payment to any person or organization.

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I hereby release, discharge and agree to hold harmless, P.A.S.S. Program, P.A.S.S. representatives, their assigns, employees or any person or persons, corporation or corporations, acting under their permission or authority, for whom P.A.S.S. might be acting including any firm publishing and/or distributing the finished product, in whole or in part, claims, costs, injuries, losses or damages of any kind arising out of or in connection with the P.A.S.S Program from and against all liability. Except where prohibited, participation in the P.A.S.S. Program constitutes participants consent to the publication of his or her name, biographical information and likeness in any media for any commercial or promotional purpose as it relates to the program, without limitation or for compensation.

I have read the foregoing release, authorization and agreement, before affixing my signature below, and warrant that I fully understand the contents thereof.

Dated: _____ Parent/Guardian Name: _____

I hereby certify that I am the parent and/or guardian of_____ participating adolescent under the age of twenty-one years. I hereby consent that any Media which are taken at P.A.S.S. events may be used in conjunction with the project, signed by the adolescent with the same force and effect as if executed by me.

_____ _____

Parent or Guardian Signature P.A.S.S. Participating Adolescent Signature

Date: _____ Date: _____

P.A.S.S. PROGRAM

(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

CONSENT AGREEMENT
Form - Must be completed by: PARENT, GUARDIAN/PRIMARY CARE GIVER, etc.
*Please print or type

I have read the program information, forms and application and I have had the opportunity to ask questions and share my concerns.

I voluntarily agree to submit the application, forms and complete the program process.

Parent/Guardian Name: _____
Please Print

Parent/Guardian Signature: _____
Signature

Today's Date: _____

SECOND PARENT SIGNATURE AS NEEDED:

Parent/Guardian Name: _____
Please Print

Parent/Guardian Signature: _____
Signature

Today's Date: _____

P.A.S.S. PROGRAM

(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

ASSENT FOR CHILDREN 13-17 YEARS OF AGE

Form - Must be completed by: ADOLESCENT and PARENT, GUARDIAN/PRIMARY CARE GIVER, etc.

*Please print or type

MY PARENT/GUARDIAN KNOWS ABOUT THIS PROGRAM AND WANTS ME TO PARTICIPATE IF I WANT TO.

I KNOW THAT I DO NOT HAVE TO PARTICIPATE IF I DO NOT WANT TO.

I DO WANT TO PARTICIPATE IN THE PROGRAM AND KNOW THAT I CAN WITHDRAW MY PERMISSION TO PARTICIPATE AT ANYTIME.

MY PARENT/GUARDIAN OR I CAN CALL THE PEOPLE LISTED ON THIS FORM IF WE HAVE ANY QUESTIONS.

Adolescent Name: _____
Please Print

Adolescent Signature: _____
Signature

Parent/Guardian Name: _____
Please Print

Parent/Guardian Signature: _____
Signature

Today's Date: _____

SECOND PARENT SIGNATURE AS NEEDED:

Parent/Guardian Name: _____
Please Print

Parent/Guardian Signature: _____
Signature

Today's Date: _____

P.A.S.S. PROGRAM

(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

P.A.S.S. PARTICIPANT APPLICATION – SECTION 2

Form - Must be completed by: ADOLESCENT

*Please print or type

Applicant's Name_____
(last) (middle initial) (first)

Phone ( )_____(Place of residence) Email: _____

Best time to call ☐ Daytime ☐ Evenings ☐ Weekends

Current Address _____

City _____ State _____ Zip _____

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Other: _____

Ethnicity: ☐ African American/Black ☐ Asian American ☐ Native American
☐ Latino/Hispanic American ☐ Bi-Racial American _____
☐ European American (Caucasian) ☐ Other: _____

If bi-racial, circle the group you identify with the most? _____

If not currently living at home, how often do you have contact with your family?

☐ Frequently ☐ Occasionally ☐ Rarely

If you have contact with family members:

Name Address Telephone Number Relationship

_____

_____

_____

*Adolescent Participant Application: continued on Next Page

Do you have children? ☐ Yes ☐ No

If yes, what are the ages: _____

Are your children living with you? ☐ Yes ☐ No

Would you have adequate child care if you participated in this program? Please explain:

_____

_____

_____

PLEASE DESCRIBE YOURSELF:

Are you currently involved in any activities or programs in your community (e.g. school, church, agency etc)? If yes, please describe:

_____

_____

_____

_____

Please tell us about school and your feelings towards school and learning:

_____

_____

_____

Do you have an IEP or 504 Plan in place? ☐ Yes ☐ No

Please describe accommodations or supports currently being provided:

_____

_____

_____

* *Adolescent Participant Application: continued on Next Page*

P.A.S.S. Applicant: _____ Confidential Information

Tell us about your interests and hobbies (what do you like to do in your spare time?):

_____

_____

_____

Do you smoke cigarettes or E-Cigarettes? ☐ Yes ☐ No

Do you have permission from your parent(s) or guardian to smoke cigarettes?
☐ Yes ☐ No

If yes, please be advised that you <u>will not</u> be allowed to smoke in the sleeping rooms or any rooms related to P.A.S.S. events.

You must agree to stay in the non-smoking room provided and adhere to the hotel's requirements where smoking is concerned.

Do you have any physical limitations or medical conditions? ☐ Yes ☐ No
Please explain:

_____

_____

Do you have any food allergies or special food requirements? ☐ Yes ☐ No
Please explain:

_____

_____

_____

Do you have any challenges/problems that your mentor needs to know about? If so, please explain:

_____

_____

_____

* *Adolescent Participant Application: continued on Next Page*

P.A.S.S. Applicant: _____ Confidential Information

What are your reasons for wanting or not wanting to be a participant in this program?
(Please be specific)

_____

_____

_____

Is it important that your mentor be of a specific age range, or ethnic background? If yes, please specify (every attempt will be made to satisfy your wishes but there's no guarantee on your specific requests):

_____

_____

_____

Are you able and willing to travel? ☐ Yes ☐ No

If you are chosen as a participant, do you agree to actively participate? ☐ Yes ☐ No

Are you willing to share your experiences? ☐ Yes ☐ No

If on medication, do you take your medication independently? ☐ Yes ☐ No

If chosen as a participant, you will be sharing a room (sleeping room with two double beds) with another participant of the same sex.

Are you currently seeing someone who is helping you with any challenges you may have keeping friends, getting along with your family and other adults (for example, teachers, religious leader (Pastor, Iman, Rabbi, coaches, etc.)? ☐ Yes ☐No

If yes, please describe in your own words the reason(s) for seeing this person:

_____

_____

_____

* *Adolescent Participant Application: continued on Next Page*

P.A.S.S. Applicant: _____ Confidential Information

List three (3) things you want to accomplish by being involved in this program:

1._____

_____

2. _____

_____

3. _____

_____

How did you hear about this program? _____

_____

_____

Name of person who referred you _____

Phone Number _____

What can you share that would contribute to a successful relationship with your assigned mentors? _____

_____

_____

Participate in any Team Sports: _____

Are you working or Volunteering? _____

If accepted for the PASS Program, kindly notify your depending teams and jobs of the dates for accepting the PASS offering.

Applicant's signature: _____Date _____

P.A.S.S. Applicant: _____ Confidential Information

P.A.S.S. PROGRAM APPLICATION
(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

SCHOOL ADMINISTRATOR – SECTION 3

Form - Must be completed by: School Administrator
*Please print or type

SCHOOL INFORMATION

Applicant's name_____

School attending_____

Address_____

Phone #_____ Fax #_____

E-mail_____

Current Grade: _____

School Counselor_____

School Principal/Administrator_____

Assigned Staff Member/School contact person: _____

Is there an IEP or 504 Plan in place for the applicant? _____

Please describe accommodations or supports currently being provided:

_____

_____

_____

Please describe applicant's attendance and attitude towards school and learning:

_____

_____

_____

* *School Administrator Application Section: continued on Next Page*

P.A.S.S. Applicant: _____ Confidential Information

Why do you think applicant should be selected to participate in this program? Please explain:

_____

_____

_____

_____

Additional comments:

_____

_____

_____

Is there any additional information that might be helpful? If yes, please specify:

_____

_____

_____

_____

Would you like to learn more about the PASS program □ **Yes** □ **No**

NOTE FOR SCHOOL ADMINISTRATORS:

Participating adolescents are given a Project assignment book in which they are expected to write in assigned school work that they would miss because of their absence from school. Workshops are usually held three times a year, Thursday through Sunday-Noon. One and one half to two hours per day of the workshop is allotted to homework. Mentors and program personnel monitor and help with homework during this time. It is helpful to us if the school assigns a member of their staff to assist us in this area. Please indicate the person to be contacted for school assignments:

Contact: _____ Phone: _____ E-mail:_____

** School Administrator Application Section: continued on Next Page*

Below is a general schedule for P.A.S.S. 2018 Workshops:

P.A.S.S. PROGRAM - 2018 WORKSHOPS			
Workshop	Workshop	Workshop	Workshop
A	**1**	**2**	**3**
Parent & Mentor	**Adolescent**	**Adolescent**	**Adolescent**
July 13 - 15	**August 23 - 26**	**October 11 - 14**	**December 6 - 9**

*Location and additional information for the (4) P.A.S.S. Workshops will be provided under separate cover.

** All involved in the Participant's life are invited to the graduation*

On occasion, the adolescents may have the opportunity to speak at conferences related to P.A.S.S. Program. If the family or child is selected, we will ensure that you are notified with a letter with the date of the conference along with a brochure/invitation (if supplied) before the event.

If there is any additional information needed for an excused absence, please notify Mr. Neville B. Morris at (585) 690-6260 work, or (607) 765-5656 cell, or via e-mail at: Nmorris@ccsi.org .

For additional program information, parents/adolescents perspectives and videos can be found at the CCSI.ORG website in Programs/PASS Program. Feel free to reach out to the program manager for additional questions.

P.A.S.S. PROGRAM APPLICATION
(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)

MENTAL HEALTH PROFESSIONAL – SECTION 4

Form - Must be completed by: Therapist, Counselor, Direct Care Service Individual

*Please print or type

* Note: Information provided does not preclude adolescent from participation in the PASS Program.

P.A.S.S. Applicant Name _____

Primary Contact Person – MUST SEE APPLICANT REGULARLY

Date_____

Staff Name_____

Title _____Credential(s)_____

Agency Affiliation: _____

Address_____

_____

Phone (_____) _____ Best time to call ☐ AM ☐ PM

Primary Therapist Name (if different from above)

_____

Title _____ Credential(s) _____

Agency Affiliation: _____

Address_____

_____

Phone (_____) _____Best time to call ☐ AM ☐ PM

E-Mail Address: _____

* *Mental Health Professional Application Section: continued on Next Page*

LOCALITY INFORMATION

Applicants County of Residence: _____

County Mental Health Director: _____

County where services are provided: _____

Address of County Mental Health Director:

_____

Phone #_____ Fax # _____

E-mail Address _____

PLEASE DESCRIBE THE APPLICANT:

Social Functioning/Interpersonal skills:

_____

_____

_____

Please describe applicant's strengths:

_____

_____

_____

Are you aware of any social activities the applicant is involved in? If yes, please describe:

_____

_____

_____

_____

* *Mental Health Professional Application Section: continued on Next Page*

Are you aware of the applicant's interests and hobbies? If yes, please describe:

_____

_____

_____

_____

Are you aware of any physical limitations or medical conditions that are a challenge to applicant? If yes, please describe:

_____

_____

_____

_____

Does applicant exhibit any behaviors the mentors and staff need to understand? 25

☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

_____

Does applicant currently take prescribed medication? ☐ Yes ☐ No

If yes, can applicant manage his /her own medication? ☐ Yes ☐ No

Note: medication must be handed to an adult and be in the proper bottle with proper dosage.

* *Mental Health Professional Application Section: continued on Next Page*

Does applicant have a history of aggressive/assaultive behavior? ☐ Yes ☐ No

If yes, please describe: How recently was behavior exhibited?

_____

_____

_____

Does applicant have a history of suicidal or self-destructive behavior? ☐ Yes ☐ No

If yes, please explain: How recently was this behavior exhibited?

_____

_____

_____

_____

Does applicant have a problem with substance use? ☐ Yes ☐ No

If yes, please explain: How recently has the applicant used this substance?

_____

_____

_____

Is the applicant experiencing challenges with establishing and maintaining friendships, interpersonal interacting with peers, neighbors, parents/guardian, family members, teachers, etc.?

Establishing and maintaining friendships	☐ Yes	☐ No
Interpersonal interacting with peers	☐ Yes	☐ No
Interpersonal interacting with neighbors	☐ Yes	☐ No
Interpersonal interacting with parents/guardians	☐ Yes	☐ No
Interpersonal interacting with family members	☐ Yes	☐ No
Interpersonal interacting with teachers	☐ Yes	☐ No

** Mental Health Professional Application Section: continued on Next Page*

a) To what extent has these behaviors impacted the child or the family?

_____

_____

_____

_____

b) If known, please list his/her most recent diagnosis:

_____

_____

Are you aware if applicant finds it challenging to focus for long periods of time; are there behavioral control issues, developmental delays, impaired decision-making abilities, lack of appropriate judgment or similar issues we should know about? ☐ Yes ☐ No

Please explain:

_____

_____

_____

_____

Is applicant generally responsive to rules and direction? ☐ Yes ☐ No

Please explain:

_____

_____

_____

_____

* *Mental Health Professional Application Section: continued on Next Page*

Do you know if applicant has a parent or immediate relative with a serious mental illness?

☐ Yes ☐ No

Why do you believe this applicant should be selected to participate in this program?

_____

_____

_____

_____

Additional comments: _____

_____

_____

_____

_____