MAIL OR FAX APPLICATION by April 17th 2020.

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

FAX: (585) 328-5211
Attn: OJJDP-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
  - Videos with Graduate parent and adolescent perspectives.
  - Program objectives, awards etc.
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 ________________________________________________
OJJDP PASS. 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: ____________________________

Or 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.

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>SEX</th>
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</table>

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 OJJDP – PASS events.

All participants must agree to stay in the non-smoking room provided and adhere to the hotel’s or location 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 a parent:
**OJJDP - PASS PROGRAM - WORKSHOPS 2020**

<table>
<thead>
<tr>
<th>WHEN</th>
<th>WHERE</th>
<th>Transportation Provided</th>
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<tbody>
<tr>
<td>Workshop #1</td>
<td><strong>Parent &amp; Mentor</strong></td>
<td></td>
</tr>
<tr>
<td>July 24 – 26, 2020</td>
<td><strong>Radisson, 175 Jefferson Rd, Rochester NY, 14623</strong></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td>Friday – Sunday Noon</td>
<td></td>
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</tr>
<tr>
<td>Workshop #2</td>
<td><strong>Youth &amp; Mentor</strong></td>
<td></td>
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<tr>
<td>Aug 13 – 16th 2020</td>
<td><strong>“” “” “”</strong></td>
<td><strong>YES</strong></td>
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<tr>
<td>Thursday – Sunday Noon</td>
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<tr>
<td>Workshop #3</td>
<td><strong>Youth &amp; Mentor</strong></td>
<td></td>
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<tr>
<td>December 11 – 13th 2020</td>
<td><strong>“” “” “”</strong></td>
<td><strong>YES</strong></td>
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<tr>
<td>Friday – Sunday Noon</td>
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<td></td>
</tr>
<tr>
<td>Graduation Family, Parent, All</td>
<td><strong>December 12” 2020</strong></td>
<td><strong>CCSI, 1099 Jay St., Bldg.-J, 3rd Flr., Rochester NY 14611</strong></td>
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<tr>
<td>Saturday 6pm – 8:30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth &amp; Mentor Saturdays</td>
<td><strong>Sept 19th 2020, 8am-5pm</strong></td>
<td><strong>“” “” “”</strong></td>
</tr>
<tr>
<td>Oct 10th 2020, 8am-5pm</td>
<td></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td>Nov 14th 2020, 8am-5pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Support Meetings All 6:30-8:00pm</td>
<td><strong>08/20, 09/17, 10/15, 11/19, 12/17, 01/21, 02/18, 03/18, 04/15, 05/20, 06/17.</strong></td>
<td><strong>CCSI, 1099 Jay St., Bldg.-J, 3rd Flr., Rochester NY 14611</strong></td>
</tr>
<tr>
<td><strong>NO</strong></td>
<td></td>
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</tbody>
</table>

- Parents/Guardians of selected applicants are expected to attend the Parent & Mentor Training and Orientation Workshop in July. Lodgings, meals and door to door transportation will be provided.
- Selected applicants usually do much better when parents attend the parent workshop and the support meetings.
- Please begin to make tentative arrangements – i.e. Time off work if applicable, and Daycare arrangements, etc. to attend.

Please submit (mail or fax) completed application by **Friday May 15th 2020**.

**MAIL or FAX APPLICATION**

Coordinated Care Services Inc.
Cultural Competency & Diversity Initiatives
Attn: OJJDP - PASS Program Application
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
The OJJDP - PASS 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 OJJDP - PASS Program.

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

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 in the transportation to or at the program venue.

Parent Signature __________ Date __________

**Note:**

*Parents, this form must be completed and collected for at the time of pick up for each OJJDP-PASS related events (Adolescent Workshops and Saturday events). 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.*
Office of Juvenile Justice and Delinquency Prevention
(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 OJJDP – PASS.

________________________________________
Parent/Guardian name

give permission to:________________________________________
Name of school / organization

Mental health professional: ________________________________
to share information about ________________________________________
Applicant name

to the Coordinator of the OJJDP - PASS Program. This information is needed so my child can be considered for participation in the program.

__________________________________________  __________________________
Parent/Guardian Signature          Date
OJJDP - PASS Program
(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
OJJDP-PASS 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 OJJDP - PASS
Program.

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):

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Parent(s)/Guardian Signature

Date

THIS FORM WILL BE RETAINED BY EVENT SUPERVISOR AND WILL ACCOMPANY THE ADOLESCENT ON EACH WORKSHOP TRIP.
OJJDP-PASS 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 OJJDP – PASS sponsored workshops.

I understand that in some instances travel to ANOTHER COMMUNITY may be a part of the OJJDP - PASS 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 OJJDP-PASS PROGRAM. While at this event, my child is subject to all rules and regulations with respect to the 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 OJJDP-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
I accept __________________________________________________________________________ as a CHAPERONE/MENTOR for my child in the OJJDP - PASS program. The Coordinator of the OJJDP – PASS 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:

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: ______________________
From time to time adolescents are in media (photo, video, etc.) taken at OJJDP-PASS events. These Medias are sometimes used in conjunction with the OJJDP-PASS 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. OJJDP-PASS 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 OJJDP-PASS 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 OJJDP-PASS Program. I grant the OJJDP-PASS Program the following rights in the use of my child’s likeness, voice or materials supplied by me or OJJDP-PASS assigned Affiliate, in a production to be produced by OJJDP-PASS. OJJDP-PASS 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. OJJDP-PASS 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.

I hereby release, discharge and agree to hold harmless, OJJDP-PASS Program, OJJDP-PASS representatives, their assigns, employees or any person or persons, corporation or corporations, acting under their permission or authority, for whom OJJDP-PASS 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 OJJDP-PASS Program from and against all liability. Except where prohibited, participation in the OJJDP-PASS 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 OJJDP-PASS 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: ___________________________  OJJDP-PASS Participating Adolescent Signature: ___________________________

Date: ___________________________  Date: ___________________________
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: ________________________________
OJJDP-PASS Applicant: ___________________________ Confidenial Information

OJJDP - PASS
(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: ________________________________________________
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
☐ Hispanic American/Latino ☐ Bi-Racial American _____________
☐ European American/Caucasian ☐ Other: _______________________

If bi-racial/other, 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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Telephone Number</th>
<th>Relationship</th>
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*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 childcare 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, team sport, 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
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 will not be allowed to smoke in the sleeping rooms or any rooms related to OJJDP-PASS events.*

All participants must agree to stay in the non-smoking room provided and adhere to the hotel’s or location requirements where smoking is concerned.

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

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

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

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Do you have any challenges/issues/preferences that if your mentor is aware of, it would make a better relationship? If so, please explain:

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

*Adolescent Participant Application: continued on Next Page*
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 most likely 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
List three (3) things you want to accomplish by being involved in this program: (Preferably things what will help to make you more successful in whatever path you choose in life.

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

Applicant’s signature: ______________________________________ Date ________________
SCHOOL INFORMATION

School Counselor______________________________________________________________

School Principal/Administrator_________________________________________________

Assigned Staff Member/School contact person: ______________________________________

Applicant’s name_______________________________________________________________

School attending________________________________________________________________

Address_______________________________________________________________________

Phone # __________________________ Fax # _________________________________________

E-mail___________________________________________________________

Current Grade: _______________________________________________________________

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
OJJDP-PASS 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 OJJDP-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 schoolwork 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 usually 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 OJJDP - PASS 2020 Workshops:

<table>
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<tr>
<th>OJJDP - PASS PROGRAM - WORKSHOPS 2020</th>
<th>WHEN</th>
<th>WHERE</th>
<th>Transportation Provided</th>
</tr>
</thead>
</table>
| **Workshop #1 Parent & Mentor**      | July 24 – 26, 2020  
   Friday – Sunday Noon | Radisson, 175 Jefferson Rd, Rochester NY, 14623 | YES |
| **Workshop #2 Youth & Mentor**       | Aug 13 – 16th 2020  
   Thursday – Sunday Noon | “ ” “ ” | YES |
| **Workshop #3 Youth & Mentor**       | December 11 – 13th 2020  
   Friday- Sunday Noon | “ ” “ ” | YES |
| **Graduation Family, Parent, All**   | December 12th 2020  
   Saturday 6pm – 8:30pm | CCSI, 1099 Jay St., Bldg.-J, 3rd Flr., Rochester NY 14611 | |
| **Youth & Mentor Saturdays**         | Sept 19th 2020, 8am-5pm  
   Oct 10th 2020, 8am-5pm  
   Nov 14th 2020, 8am-5pm. | “ ” “ ” | YES |
| **Parent Support Meetings All 6:30-8:00pm** | 08/20, 09/24, 10/15, 11/19, 12/17, 01/16, 02/20, 03/19, 04/16, 05/21, 06/18. | CCSI, 1099 Jay St., Bldg.-J, 3rd Flr., Rochester NY 14611 | NO |

- On occasion, the adolescents may have the opportunity to speak at conferences related to OJJDP-PASS Program.

- There is a graduation ceremony on the Saturday of the final workshop where friends, families and those who play a role in the adolescents’ life are all invited to attend.

- 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’ perspective and videos can be found at the CCSI.ORG website in Programs/OJJDP-PASS Program.
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 OJJDP-PASS Program.

OJJDP-PASS 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?

☐ 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?

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Additional comments: __________________________________________

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Therapist, page 6 of 6

END of Section -4

Revised 3/5/2020