

The CIT applicant is:

Presently a client at West Bergen A former client at West Bergen Not and has never been a client at West Bergen

How did you find out about the SOAR Experience and the CIT program? _____

2. Family Information:

Parent-Guardian #1

Parent-Guardian #2

Name

Name

Relationship to the CIT applicant

Relationship to the CIT applicant

May we contact this person? ____ Yes ____ No

May we contact this person? ____ Yes ____ No

Address

Address

(____) _____
Home Phone

(____) _____
Home Phone

(____) _____
Work Phone

(____) _____
Work Phone

(____) _____
Cell Phone

(____) _____
Cell Phone

E-Mail (Please print clearly)

E-Mail (Please print clearly)

3. Emergency Contacts for CITs:

Please identify **at least 2 and up to 4** people (**other than parent/guardian**) who may be contacted should your parent or guardian not be reachable between 8:30 AM and 4 PM. These are contacts for emergency purposes.

Name:	Telephone Number(s):	Relationship to CIT applicant:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

4. Trip Permission or agreement

I give my child or adult with guardianship permission to take walking trips and van/bus trips with West Bergen SOAR Staff. () Yes () No

Or:

I am over 18 and my family members do not have guardianship. I understand that as part of my role as a CIT, I will be expected to go on walking trips and van or bus trips with the campers and staff. I agree to attend all trips as determined by the camp administration. () Yes () No

5. Dismissal Procedure for CITs

Parents are encouraged to pick up their minor aged child or adults with guardianship if walking is not an option.

I give my minor aged child (who is 14 years of age or older) or adult with guardianship, permission to walk home alone or take public transportation at CIT dismissal time. () Yes () No

Or:

() I have made arrangements for my minor aged child (who is 14 years of age or older) or adult with guardianship, to be transported by (identify means/persons involved/contact information):

People permitted to pick up the minor or adult with guardianship CIT applicant:

Name	Relationship to CIT	Day Time Phone	Cell Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Or:

() I am over 18 and my family members do not have guardianship. My transportation to and from camp will be by: (Please state if driving self; walking, public transportation or transport by another person and identify that person and phone number below):

If you do not want your child or adult with guardianship to be picked up by a specific adult, please answer all of the following questions (A-C).

A. My child/adult with guardianship **MAY NOT** be picked up by the following individual because there is an active order of protection

Name _____ Docket # _____ Expiration Date _____

B. My child/adult with guardianship is aware of this order and will report this adult to a West Bergen Staff member () Yes () No

C. I realize that there is no easy way of monitoring who picks up my child or adult with guardianship after camp. If I think this may be a problem, I will make an appointment with the Camp Director at 201-934-1160 to set up a special procedure for dismissal.

() Yes, I think there may be a problem () No, I do not anticipate any problems

6. About the CIT applicant (please use separate page if necessary). We encourage family members to do this in collaboration with the applicant. It would be helpful to know if the answers are from the applicant’s perspective, the parent or guardian’s perspective, or both.

Applicant's strengths:

Applicant's Challenges:

Applicant's social communication skills (i.e. appropriate and successful initiation of conversations, maintaining and ending conversations with others, asking for assistance when needed, communicating one on one verses in a group setting, etc. Please describe both strengths and areas in need of further developing.) :

Applicant's activities and peer relationships (what do you like to do in your spare time, what type of organizations/activities are you involved in, special interests, talents, what are your peer relationships like, describe other relationships in your life that are meaningful to you, etc.):

Identify all sensory, motor, behavioral, nutritional or additional issues that would help us to work more effectively in making this a successful experience for the CIT applicant:

Has the applicant had any incidents of aggression and/or self-injurious behavior at school, home or community during the last 12 months? Please describe.

Have there been any hospitalizations or emergency assessments during the applicant's life for social-emotional-behavioral issues? This includes PESP visits, Emergency Room visits, emergency risk assessments or visits from Children's Mobile Crisis. If yes, please state when and describe briefly.

Please describe CIT applicant's past camp experiences. Write "none" if not applicable.

Please describe CIT applicant's past work experience. Write "none" if not applicable.

Please describe CIT applicant's past volunteer experience. Write "none" if not applicable.

Please describe CIT applicant's experience with younger children. Include experiences in terms of working, caretaking, family, play, volunteer, groups they are a part of, etc. Please note age ranges below.

6 – 8 year olds:

9 -12 year olds:

13 – 15 year olds:

What are your goals for participating in the CIT program? What skills do you hope to develop, enhance, etc? What experiences do you hope to gain?

7. Release and Authorization

I give permission to The SOAR Experience program staff and West Bergen Mental Healthcare or its agents to obtain educational/psychological/medical/service information about my minor child or adult with guardianship from school, other educational sources, housing system, doctors, therapists, counselors, or other professionals if necessary in order to evaluate CIT acceptance and placement. This authorization shall be effective until revoked by me in writing and delivered to the West Bergen Mental Healthcare SOAR Experience Director or the Clinical Director of Asperger's Related Services.

Parent/Guardian Signature: _____ Date: _____

I am aware of and in agreement with my parent or guardian allowing for the release of information stated above and signed by my parent or legal guardian.

Minor/Adult with Guardianship Signature: _____ Date: _____

Or:

I give permission to The SOAR Experience program staff and West Bergen Mental Healthcare or its agents to obtain educational/psychological/medical/service information about me from school, other educational sources, housing system, doctors, therapists, counselors, or other professionals if necessary in order to evaluate CIT acceptance and placement. This authorization shall be effective until revoked by me in writing and delivered to the West Bergen Mental Healthcare SOAR Experience director or the Clinical Director of Asperger's Related Services.

Applicants 18 and over with no guardianship: _____ Date: _____

8. Photo/Video/Interview Consent

** Please note:* It is extremely difficult to separate the CITs from SOAR participants in photos and videos. CITs often feel excluded when they are asked to move out of the view of the camera lens.

Note: The use of the term “non-identifying” in the selections below is being used to indicate that your name would not be used or attached to the photograph.

*I understand that the SOAR Program features special events both in our facility and away from our facility where photos or videos may be taken. In addition, part of the social skills programming involves video taping participants practicing their skills and then reviewing those tapes. The CITs and staff will likely be in such videos as well. We would also like to be able to use photos and/or video recordings of the SOAR program and the CIT program for educational, marketing and fund raising purposes. Please acknowledge your agreement with each statement below by initialing each statement. If you are a minor or adult with guardianship your parent or guardian must initial as well.

Your	Parent/Guardian
Initials	Initials

- _____ I agree to photographs (of me alone or of me and others) to be brought home.
- _____ I agree to photographs (of me alone or me and others) to be able to go home with a participant or CIT.
- _____ I agree to photographs (of me alone or of me and others) for use within the program (i.e. during group time, posted on walls or bulletin boards, to assist in identifying me on trips, etc.).
- _____ I agree to be in a non-identifying photograph that may be used in a West Bergen presentation aimed at increasing awareness and educating others about Asperger's and the spectrum, The SOAR Experience, the CIT program or the work of the Asperger's Related Services department.
- _____ I agree to be in a non-identifying photograph that may be used to report on or promote the The SOAR Experience or The SOAR Experience's CIT program.
- _____ I agree to be in a non-identifying photograph that may be used in a West Bergen publication.
- _____ I agree to be in a non-identifying photograph that may be used for marketing programs by West Bergen Mental Healthcare.
- _____ I agree to be in a non-identifying photograph that may be used for fund raising purpose by West Bergen Mental Healthcare.
- _____ I agree to video recordings (of me alone or me and others) to be able to go home with a participant or CIT. This would involve SOAR based programs being recorded. Examples include, but are not limited to recordings of field trips, a parade or a performance.
- _____ I agree to video recordings (of me alone or me and others) for use within the program.
- _____ I agree to be in a non-identifying video recording that may be used in a West Bergen presentation aimed at increasing awareness and educating others about Asperger's and the spectrum, The SOAR Experience, the CIT program or the work of the Asperger's Related Services department.
- _____ I agree to be in a non-identifying video recording that may be used to report on or promote The SOAR Experience or The SOAR Experience's CIT program.
- _____ I agree to be in a non-identifying video recording that may be used in a West Bergen publication.
- _____ I agree to be in a non-identifying video recording that may be used for marketing programs by West Bergen Mental Healthcare.

_____ I agree to be in a non-identifying video recording that may be used for fund raising purpose by West Bergen Mental Healthcare.

The undersigned, on his or her own behalf and on behalf of the minor child or adult with guardianship, as well as on behalf of all of the undersigned and child or adult with guardianship's heirs, successors and/or assigns, does hereby release WBMHC and its and their heirs, successors, and/or assigns from any and all claims, demand, and liability of whatever kind, including but not limited to payment of any compensation, for misappropriation or misuse of any publicity, trademark, copyright, or other rights of the child or adult with guardianship and/or undersigned and their heirs, successors and/or assigns, arising out of photographs/video recordings of you or your child or adult with guardianship.

Parent/Guardian Signature: _____ Date: _____

Minor Child/Adult with Guardianship Signature: _____ Date: _____

Applicants 18 and over with no guardianship: _____ Date: _____

I give my child or adult with guardianship permission to participate in The SOAR Experience's CIT program.

All of the information I provided is true. I understand that all consent information I provided will be in effect as of the date of my signing this form and will continue as long as my child or adult with guardianship is enrolled in this CIT program.

Parent/Guardian Signature: _____ Date: _____

Minor Child/Adult with Guardianship Signature: _____ Date: _____

Or: I agree to participate in The SOAR Experience's CIT program. All of the information I provided is true. I understand that all consent information I provided will be in effect as of the date of my signing this form and will continue as long as I am enrolled in this summer CIT program.

Applicants 18 and over with no guardianship: _____ Date: _____

9. **Payment Information**

A \$200 application fee is required at time of application for all counselor in training (CIT) applicants. Applications must be completed in full and returned with all requested records. An interview may also be required. The application, record review and interview assist in predicting whether this CIT program is a good fit for you (or your child/adult with guardianship). The application fee will be returned in full should applicant not be accepted or the minimal registration for the summer program not be reached. Unlike most summer programs, there is no additional tuition cost for the CITs. A significant portion of the funding for the CIT program has been made possible through a grant from the Doug Flutie Jr. Foundation.

Total Enclosed: ____ \$200 Application Fee

Check Am Ex MC Visa Other

Credit Card Number: _____ Ex. Date: _____

Signature: _____ *by signature, I authorize the above credit card to be charged*

10. Services and Service Provider Information

Type of therapy/services applicant is receiving: _____ Reason For Service: _____ Provider Name: _____ How long in this service: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	Type of therapy/services applicant is receiving: _____ Reason For Service: _____ Provider Name: _____ How long in this service: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

11. Other Provider Information (if applicable)

Case manager: _____ Address: _____ Reason For Service: _____ City: _____ ST: _____ Zip: _____ Phone: _____ Fax: _____	Therapist: _____ Address: _____ Reason For Service: _____ City: _____ ST: _____ Zip: _____ Phone: _____ Fax: _____
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12. Diagnostic and Classification Information:

Psychiatric Diagnosis: _____ Educational Classification: _____ _____
*Copies of most recent diagnosis and evaluations, including IEP (if classified) MUST accompany this application
<input type="radio"/> Diagnostic evaluation _____ <input type="radio"/> Evaluations attached – Identify _____ <input type="radio"/> IEP attached (Please include all evaluations and reports used to generate the IEP)

13. Emergency Medical Care

CIT Applicant's Name: _____ Date of Birth: _____

1. If my child/adult with guardianship requires emergency medical care and I cannot be reached, I give my consent to The SOAR Experience and West Bergen Mental Healthcare to obtain the necessary medical care for my child/adult with guardianship. I agree to pay all of the costs associated with the emergency medical care that my child/adult with guardianship received. I understand that every effort will be made to contact me before and after medical care is provided.

Parent/Guardian Signature: _____ Date: _____

Minor Child/Adult with Guardianship Signature: _____ Date: _____

Or:

If I require emergency medical care, I give my consent to The SOAR Experience and West Bergen Mental Healthcare to obtain the necessary medical care on my behalf. I agree to pay all of the costs associated with the emergency medical care I might receive. I understand that every effort will be made to consult with me before and after medical care is provided.

Applicants 18 and over with no guardianship: _____ Date: _____

2. Health/Insurance Information:

CIT Applicant's Primary Doctor: _____ (Fill in all information on this physician in 1st box below)

Insurance Company: _____ Policy Holder's Name: _____

Insurance ID Number: _____ Religious Preference: _____

14. Other Medical Information:

If accepted, please attach a letter to this application from applicant's primary physician stating the applicant's general health, any medical conditions, medications prescribed and vaccination status. For those taking medication, you will be required to produce prescription documentation for medication distribution onsite and medication must come to the site in its' original container.

Applicant's Primary Physician:	Applicant's Other Doctor:
_____	_____
Type of Physician: _____	Type of Physician: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

15. Medication(s) and Dosages(s): _____

16. Food Allergies, Dietetic needs, other allergies

- The applicant has no known food allergies and/or other restrictions.
- The applicant has the following food allergies and/or food restrictions: _____

- The applicant has the following non-food related allergies: _____

- I am an adult and will be monitoring my own foods.
- I give permission for my child/adult with guardianship to eat meals or snacks provided by the program
- I do not give permission for my child/adult with guardianship to eat meals or snacks provided by the program. My child/adult with guardianship will bring his/her own snack and lunch.
- My child/adult with guardianship knows not to eat the foods mentioned below and will ask about the ingredients of a particular food if he/she is unsure of the contents.

Parent/Guardian Signature: _____ Date: _____

Minor Child/Adult with Guardianship Signature: _____ Date: _____

Applicants 18 and over with no guardianship: _____ Date: _____

