West Bergen Mental Healthcare
Where Health Comes to Mind

The SOAR Experience CIT Program

Level 1 Autism Services Department

Counselor In Training APPLICATION and REGISTRATION Form (2017)

Completion of this form is necessary for all applicants to the Counselor in Training (CIT) Program at The SOAR Experience. In addition, prospective CIT candidates will be required to attend an interview for the position which will determine if the candidate will be chosen to participate in The SOAR Experience's CIT program.

Application Deadline: May 12, 2017

If available, please attach an individual picture of the potential participant

1. Counselor In Training (CIT) Information

Applicant's Name: _____ Date of Birth: _____

Biological sex: ( )Female ( )Male ( )Intersex/DSD

Gender Identity: ( ) Man ( )Woman ( ) Trans ( )Transgender ( )Transsexual ( )Genderqueer
(OPTIONAL)

T-shirt size (circle one): S M L XL XXL XXXL

Grade (or highest grade completed): _____ School (circle present or past): _____

For those presently enrolled in school, please check any of the following that apply:

___ In College ___ To start College in Fall ___ Not presently in college

___ Mainstreamed ___ Mainstreamed with Supports ___Self - Contained Classroom

___ Out of District Placement ___ Home Schooled

Check appropriate status as of July, 2017: _____ Minor (14 – 18) _____ Adult (18 +)

For those Adults (18 and above), do you have a guardian? _____ Yes _____ No

If you checked "Yes" to having a guardian, please identify guardian and state type of guardianship below. Also include a copy of the guardianship document with this application:

Name of Guardian:_____ Type of guardianship: _____

Guardian's phone number: _____

Living Situation (circle one): Independent With family Supported Housing Group Situation

Home Address:

_____

Street Apt# City State Zip Code

Home Phone: _____ Cell Phone: _____

Language(s) spoken at home: _____ Does your parent or guardian speak English? Yes ( ) No ( )

The CIT applicant is:

( ) Past CIT Program Participant
( ) Former West Bergen Client
( ) Former SOAR Participant
( ) Current West Bergen Client (Therapist: _____)
( ) 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

_____
Name

_____
Relationship to the CIT applicant

May we contact this person? ____ Yes ____ No

_____
Address

(____)_____
Home Phone

(____)_____
Work Phone

(___)_____
Cell Phone

_____
E-Mail (Please print clearly)

Parent-Guardian #2

_____
Name

_____
Relationship to the CIT applicant

May we contact this person? ____ Yes ____ No

_____
Address

(_____)_____
Home Phone

(_____)_____
Work Phone

(____)_____
Cell Phone

_____
E-Mail (Please print clearly)

Current parental status:

( ) Married ( ) Separated ( ) Divorced ( ) Never married
( ) Both parents living in same home as applicant ( ) Parents living apart in separate homes

Household members: Please list every member of the household:

NAME AGE (of family members) RELATIONSHIP

_____

_____

_____

_____

***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):

_____

_____

<u>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).</u>

A. My child/adult with guardianship **<u>MAY NOT</u>** 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 <u>(please use separate page if necessary)</u>. 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:

Does the applicant use any assistive technology devices to optimize his/her functioning at school, home or socially/within the community? Has the applicant benefitted from such devices in the past? Will the applicant be bringing any such devices to the SOAR Experience? If yes to any of the above, please identify devices, typical amount and purpose of use, etc:

Applicant's preferred coping strategies/tips for when they are struggling/what distracts them:

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 – 16 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?

Is there a specific activity that the applicant might need accommodations to accomplish? (Please note: CITs will be expected to accompany children on walking and bus trips and are expected to assist with all activities including swimming). Are there any fears, anxiety, sensory issues, coordination issues, etc that would affect your ability to handle certain activities or trips (i.e. fear of the dark or clowns or bugs, poor swimmer, etc.)?

Is there any family or cultural factors that you think would be important for the SOAR Experience staff to be aware of while working with you in the CIT program?

7. 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. 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. Please 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 videotaping participants practicing their skills and then reviewing those tapes. The CITs and staff will likely be in such videos as well. West Bergen 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 Initials	**Parent/Guardian 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 the Autism spectrum, The SOAR Experience, the CIT program or the work of the Level 1 Autism Services department.
_____	_____	I agree to be in a non-identifying photograph 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 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 the Autism spectrum, The SOAR Experience, the CIT program or the work of the Level 1 Autism 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:_____

8. Services and Service Provider Information:

Type of therapy/services applicant is receiving: _____	Type of therapy/services applicant is receiving: _____
Reason For Service: _____	Reason For Service:_____
Provider Name:_____	Provider Name:_____
How long in this service: _____	How long in this service: _____
Address:_____	Address:_____
City:_____State:_____Zip:_____	City:_____State:_____Zip:_____
Phone:_____Fax:_____	Phone:_____Fax:_____

Additional Provider Information (if applicable)

Case manager:_____	Therapist:_____
School/Agency: _____	Agency: _____
Address:_____	Address:_____
Reason For Service: _____	Reason For Service: _____
City:_____ST:_____Zip:_____	City:_____ST:_____Zip:_____
Phone:_____	Phone:_____
Fax:_____	Fax:_____

9. Diagnostic and Classification Information:

Psychiatric Diagnosis:_____

Educational Classification: _____

★**Copies of most recent diagnosis and evaluations, including IEP (if classified) MUST accompany this application**

★**Please check off all of the following that have been included with the application:**

☐ Diagnostic evaluation completed by_____
☐ Evaluations attached – Identify_____
☐ **IEP and ALL EVALUATIONS/REPORTS used to *generate* the IEP attached**

10. 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. All CITs with allergies requiring a prescription for an Epinephrine Injection pen (EpiPen) must provide an EpiPen to be left at the SOAR Experience for the duration of the program.

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:_____

List all Present Medical Conditions and related treatments (including any information regarding vision, hearing or mobility): _____

_____

_____

Medication(s) and Dosages(s):_____

_____

Past Medical History: _____

_____

Vaccination History:

( ) I received all vaccinations to date.
( ) I received all vaccinations except the following: _____
( ) I have not received any vaccinations to date.

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.

Other Sensitivities (i.e. sun, sun block, bug repellent, etc.) _____

11. 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: _____

12. 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 Level 1 Autism 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 Clinical Director of Level 1 Autism Services.

Applicants 18 and over with no guardianship:_____Date:_____

13. Permission to Attend:

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:_____

Parent/Guardian Signature: _____Date:_____

Minor Child/Adult with Guardianship Signature: _____Date: _____

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

14. Payment Information

A **$600** 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 is not reached. Application fees are **non**-refundable if candidate is accepted, accepts the slot and later decides to drop out of the program. Please note, that there are a limited number of slots available and numerous applicants. Unlike most summer programs, there is no additional tuition cost for the CITs.

Has any third party, such as an agency or school district agreed to fund the applicant's participation in the SOAR Experience CIT program?

Yes ( ) No ( ) If so, third party name:_____

Contact person:_____ Contact information: _____

Total Enclosed: ___ $600 Application Fee

by: □ Check □ Cash

****Please note: If you would like to make your payment via credit card, it must be done in person or over the phone. Please call Amy Whritenour at 201-934-1160 should you wish to make arrangements to pay over the phone. West Bergen accepts the following credit cards - Mastercard, Visa, American Express, Discover*

Please Return Completed Application to and For Further Information Contact:
The SOAR Experience CIT Program Supervisor, Richard Miller, LAC, NCC or
Clinical Director Alain Mollinedo, Ed.D, LCSW
West Bergen Mental Healthcare
1 Cherry Lane
Ramsey, NJ 07446
201-934-1160 x7234
www.westbergen.org

Please Note:
The SOAR Experience/ SOAR Experience CIT Program will take place at West Bergen's Ramsey Location:
One Cherry Lane, Ramsey, NJ 07446 201-934-1160 www.westbergen.org

...the SOAR Experience