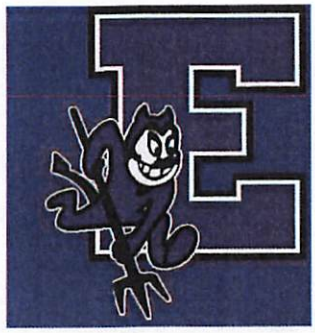
A.S.Y.S.S.T
Available School Youth Services Support Team



Program Director
Daniel Winter

Youth Development Specialist
Shakita Johnson

Mental Health Clinician
Carly Scanlon, MA, LAC, NCC

ASYSST Intake Package

DESCRIPTION OF SERVICES:

ASYSST School Based Youth Services Program (SBYSP) at Ewing High School offers a variety of year-round intervention, recreational, and support services to our students in a warm and supportive environment. Our mission is to enrich and enhance the lives of youth; thereby increasing their likelihood for completing their education and developing the skills necessary for employment, a trade, or higher education. We want to help students navigate their adolescent years and be healthy! Our activities and events are free of charge, open to all Ewing High School students and their families. Services are structured for the purpose of youth achieving their goals as well as positive emotional growth. Our services include individual counseling, group counseling, learning support, career planning, after school recreation, college planning, and when necessary, referrals to community-based agencies.

STUDENT INFORMATION

Last name:_____ First Name:_____

Nickname:_____ Student ID#:_____

Birth Date:___/___/____ Age:_____ Gender: Male ☐ Female ☐

Grade:_____ Anticipated Graduation Year:_____

Home Address:_____ Apt#:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Student's Cell:_____

Student's Email:_____

CONTACT US:

ASYSST is located at Ewing High School, 900 Parkway Avenue, Ewing, NJ 08618.
Phone 609-538-9800 ext. 2173
ASYSST is managed by Mercer Council on Alcoholism and Drug Addiction. Funded by New Jersey of Children and Families

ASYSST Coordinator Signature/Receipt_____ ASYSST Staff Assignment_____

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PARENT or GUARDIAN:

Primary Contact #1: ☐ Parent ☐ Guardian ☐ Other:_____
Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ (W):_____ (C):_____
Email:_____

PARENT or GUARDIAN:

Primary Contact #2: ☐ Parent ☐ Guardian ☐ Other:_____
Name:_____
Address_____ City:_____ State:_____ Zip:_____
Home Phone:_____ (W):_____ (C):_____
Email_____

Adults living with student: ☐ Mother ☐ Father ☐ Grandparents ☐ Stepparent ☐ Other(s):_____

EMERGENCY INFORMATION:
Physician's Name:_____ Phone Number:_____

Health Insurance: ☐ Medicaid ☐ Family Care ☐ HMO ☐ Private ☐ Reduced Care ☐ Don't Know ☐ None

In the event the parent(s) or guardian can not be reached please contact:
Name:_____ Relationship:_____
Home phone:_____ (W):_____ (C):_____

Name:_____ Relationship:_____
Home phone:_____ (W)_____ (C)_____

Does your child have medical conditions, allergies, or special needs that the staff should know about?_____
Is your child taking any medications to treat conditions?_____

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REFERRAL INFORMATION:

Who is referring the student to ASYSST?:_____

Briefly describe the types of services your child would benefit from:

_____

_____

_____

_____

_____

HOUSEHOLD INFORMATION:

Ethnicity: (Click all that applies)

- ☐ Black/African American
- ☐ White(Not Hispanic or Latino)
- ☐ Hispanic
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other:_____

Primary Language Spoken in the Home:_____

Estimated Annual Family Income:

☐ Under $10,000 ☐ $15,000-$24,999 ☐ $25,000-$34,999 ☐ $35,000-$49,999 ☐ $50,000-$74,000
☐ $75,000-$99,000 ☐ $100,000-$149,000 ☐ $150,000-$199,00 ☐ Over $200,00

Please check the box of the following services you have used in the past or would like more information about:

- ☐ Foster/Kinship Care/Adoption — ☐ Would like more information about Foster/Kinship Care/Adoption
- ☐ Food Stamps — ☐ Would like more information about Food Stamps
- ☐ Medicaid — ☐ Would like more information about Medicaid
- ☐ Division of Children & Families — ☐ Would like more information about Division of Children & Families
- ☐ Work First NJ — ☐ Would like more information about Work First NJ
- ☐ NJ Family Care — ☐ Would like more information about NJ Family Care
- ☐ Child Support Services — ☐ Would like more information about Child Support Care
- ☐ Pre-natal/Post Partum Services — ☐ Would like more information about prenatal Care/Postpartum Depression
- ☐ Home Energy Assistance Programs — ☐ Would like more information about Home Energy Assistance program

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ASYSST Records Release Authorization

***Please note this Release of Information is valid for one year from date of signature.*
***If you are under 18 years old you need a parent or guardian to sign this form!*

The information contained in this form is CONFIDENTIAL and will be utilized in compliance with all Federal and State confidentiality laws

This release of information is valid for one year: From _____ To _____

STUDENT NAME (Print): _____ **DOB:** _____

I AUTHORIZE _____ **TO RELEASE/RECEIVE INFORMATION TO/FROM:**
(Name of agency/school/medical provider which is to make/receive disclosure)

ASYSST
School Based Youth Services Program at Ewing High School
900 Parkway Ave., Ewing NJ 08618
609-538-9800 ext. 2173

INFORMATION THAT MAY BE RELEASED:
Mental Health/Physical Information ( ) Presence and Progress in Treatment ( ) Assessments ( ) Diagnoses ( ) Tx/Recovery Plan(s) ( )
Psychological/Psychiatric Evaluation ( ) Medication Records ( ) Medical Health Records ( ) Demographic Information ( )

Drug/Alcohol Treatment Information: Attendance and Progress in Treatment ( ) Assessments ( ) Diagnoses ( ) Tx/Recovery Plan(s) ( )
Medication Records ( ) Demographic Information ( ) Medical Health Records ( )

( ) Other (specify): _____

REASON: Continuity of Care ( ) Interagency Correspondence ( ) Compliance with Program/Service ( )
Legal Purposes ( ) Insurance/Managed Care ( ) Social Security/Disability ( )

I understand that my health information is protected under the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclose as prohibited, and the Health Insurance portability and Accountability Act of 1995 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclose by the recipient and longer will be protected by the HIPAA privacy Law.

1. Review and understand the Notice of Privacy Practices;
2. This authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization;
3. Inspect and receive a copy of the material to be released;
4. Request restrictions on how my health information is used and disclosed; and
5. Receive a copy of this authorization and the Notice of Privacy Practices

_____ _____
(Signature of parent or legal Guardian) Date

_____ _____
Witness Signature Date

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NJ SCHOOL BASED YOUTH SERVICES PROGRAM (SBYSP)
Evaluation Form

Dear Parent/Guardian or enrolled student 16 years and older:

The New Jersey Department of Children and Families(DCF), Division of family and Community Partnership(FCP), Office of School Linked Services(OSLS) is pleased to continue supporting the NJ School Based Youth Services program(SBYSP) that is available to your high school child.

The NJ SBYSP began in 1987 and continues today with the goal to help young people navigate their adolescent years, finish their education, obtain skills leading to employment or continuing education, and graduate healthy and drug free.

When you consent to your child's participation in the NJ SBYSP you are committing to your child's ultimate goal of graduating high school. The SBYSP is available in 67 high schools and it is important that we continuously ensure the programs are achieving its goal. As a result, each program is required to use the following two tools to determine their impact. The two tools contain less than 15 questions related to your child's thoughts about the program and/or their high school graduation goal.

- The NJ SBYSP High School impact Evaluation will be provided anonymously to students that participate in a program activity during the months of October and March.
- The Resiliency Tool will be provided to students that have participated in at least 6 school based activities throughout the school year.

When reports are produced **individuals students will** not be mentioned

Students are not required to complete the evaluation, this is truly voluntary. They also have the right to discontinue participating at any point. No action will be taken against the school, you, or your child, if your child does not take part.

As a parent/guardian you can review a blank copy of these two tools by opening the link on this page.

At this time, we are asking for your written consent for your child to participate or your written refusal. We ask that you return the signed form in either case. Have your child return the form to the SBYSP right away regardless of whether or not you allow your child to participate.

☐ YES, may participate with these evaluations.
☐ NO, may not participate with these evaluations.

Child's Name:_____ Grade:_____8th _____9th_____10th_____11th_____12th

Student signature if 16 years or older:_____
Parent's Signature:_____
Date:_____

Effective July 1, 2016

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ASYSST Parental Consent/Media Release

Many of our activities and events are offered at the School-wide level, such as groups and guest speakers aimed at promoting healthy youth development, violence prevention, pregnancy prevention, and to assist with career development, general health, personal safety, and social awareness. Our individual and group services include school-based mental health counseling, career planning, employment counseling, internship, mentoring, college planning, learning support, after-school recreation, peer leadership activities, field trips, events for parents, and other healthy youth activities. Participation in any of our services is voluntary. Consent and registration are required. School policies and procedures are observed regarding trips, attendance, substance abuse, and confidentiality. By signing below, the parent/guardian is providing consent for their child to receive the services listed above, unless otherwise indicated.

I understand that all services provided by ASYSST are Voluntary, free & confidential. ☐ YES ☐ NO
I do not wish my child to be provided with the following services:
_____

Clinical Documents may only be released with consent. However, you should be aware that ASYSST staff may be required to disclose client information, even without consent, in the following situation:

- When doing so is necessary to protect your child or someone else from imminent physical and/or life-threatening harm.
- When a client lacks the capacity or refuses to care for him/herself and such lack of self care presents substantial threat to his or her well being.
- When the abuse, neglect, or exploitation of a child, elder adult, or dependent adult is suspected.

I give permission for my child to receive services listed above, offered by the School Based Youth Services Program at Ewing High School beginning today until he/she graduates or is no longer enrolled at Ewing High School. ☐ YES ☐ NO

I understand that I can withdraw or revoke my student's participation at ASYSST in writing at any time, but this will not affect information or services that had already been provided/shared. ☐ YES ☐ NO

Parent/guardian Signature:_____ Date:_____

Media Release:
I grant permission for any and all photographs and videos of my child(ren) taken during their participation with the ASYSST program to be used by ASYSST and Mercer Council on Alcohol and Drug Addiction(MCADA) for promotional use in, but not limited to, television, newspapers, magazines, brochures, camp newsletters, and online media (such as Social Media, the ASYSST program and MCADA websites, etc.). I understand that no personal information will be associated with any photographs or taken by the ASYSST are the property of ASYSST and MCADA.
☐ YES ☐ NO

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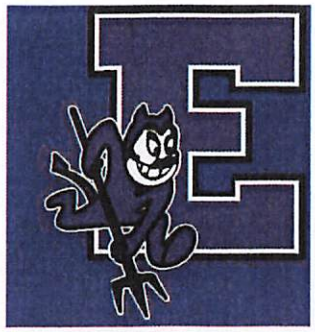

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ASYSST CONFIDENTIALITY FORM

Student Rights:

You have a right to have:

1. Reasonable access to considerate, empathetic and respectful care by competent staff.
2. Receive care regardless of race, religion, sex, national origin, age, disability, or life-style!
3. Informed consent to participate in, or refuse any service.
4. Information regarding your needs and services will be kept confidential and your personal privacy and dignity respected.
5. Request to refuse the release of information regarding your services or records, unless otherwise required by law.
6. Present complaints and receive a response within a reasonable time period.
7. Receive SBYSP services free of charge.

Everything a student shares, tells, and/or discloses to an ASYSST counselor is CONFIDENTIAL (by law)! Our policy is that the things we talk about ASYSST are private. They will not be shared with others, unless.....

1. You say you are going to hurt yourself.
2. You say you are going to hurt someone else.
3. You say that you are going to commit any type of violent crime.
4. You have a weapon.
5. You disclose that you or another minor are being abused (sexually, physically, and/or mentally)
6. You are sexually involved with someone older or younger that you and it does not meet legal guidelines.
7. You disclose that you are going to run away from home.
8. You disclose that you have had alcohol or drugs before school or during school; or if you appear to be under the influence of alcohol or any other illicit drugs.

⇦ If these situations occur ASYSST WILL HAVE to share them with your parents or the authorities because **WE WANT TO KEEP YOU SAFE!!!!**

*******Any student who discloses any form of drug use will be confidentially referred to Ewing High School's Substance Awareness Coordinator (SAC)********

_____ DATE:___/___/___
STUDENT SIGNATURE

_____ DATE:___/___/___
PARENT/GUARDIAN SIGNATURE(IF UNDER 16)

_____ DATE:___/___/___
SIGNATURE/TITLE OF STAFF COMPLETING FORM

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