

PASS PROGRAM FAMILY APPLICATION- 2025

Monroe County

Prevention, Access, Self-Empowerment and Support

The PASS (Prevention Access Self-Empowerment and Support) is a mentoring program for Monroe County adolescents ages 13 to 17 who are facing challenges in their daily lives. Adolescents learn life skills such as anger management, self-esteem building, job interviewing skills, decision making, goal setting, personal social skills, self-motivating skills and much more. The program provides an environment to practice what they learn and how to use the new skills for creating a path towards-lifelong goal. The program is of no cost to the families, and covers, transportation, meals, materials, social events, lodging and accommodations.

Each family is assigned a junior mentor for the adolescent and an adult mentor for the parents/guardians. The workshops for the adolescents are separate from those of the parents. Community leaders on occasion make presentations at the workshops to the families. Adolescents usually do much better when their parents are active participants in the program. The program is highly participatory and designed to engage adolescents and their families through learning in a fun environment. The program engages a continuous improvement model.

PASS is sponsored by Monroe County Office of Mental Health and managed by CCSI (Coordinated Care Services Inc.) The PASS Program was established in 1996 and has supported parents and adolescents from across the state of New York. One of the foundational principles of the PASS Program is based on the "Eight Keys of Excellence." They are

- * Speak with good purpose,
- * Stay flexible,
- * Affirm your commitment,
- * Take ownership
- * Keep your balance
- * Live in the now – this is it,
- * Live in integrity
- * Acknowledge that failure leads to success.

For additional information, videos, and testimonies, go to <https://ccsi.org/Programs/PASS-Program> or contact the program manager Neville Morris at Nmorris@ccsi.org (585) 341-2230work, (607) 765-5656cell, (585) 328-5211Fax.

EMAIL, MAIL OR FAX APPLICATION by June 20th, 2025.

**ADDRESS: Coordinated Care Services Inc.
Cultural Competency & Diversity Initiatives Attn: PASS Program
1099 Jay St. Building J, 3rd Floor, Rochester, NY 14 2026611.**



**PASS PROGRAM FAMILY APPLICATION
(PREVENTION, ACCESS, SELF-EMPOWERMENT AND SUPPORT)**

PARENT, PRIMARY CARE GIVER SECTION 2025

PARENT OR GUARDIAN PRIMARY CONTACT:

Name _____ first, _____ last
Address/Street _____
City _____, State _____, zip _____
Phone _____ Cell, _____ work, _____ Hm
Email _____, Relationship w/Applicant _____

OTHER PARENT/GUARDIAN:

NAME _____ first, MI _____, _____ last
Address/Street _____
City _____, State _____, zip _____
Phone _____ Cell, _____ work, _____ Hm
Email _____, Relationship w/Applicant _____

ADOLESCENT:

NAME _____, Date of Birth _____
Address _____
Phone _____, Email _____

WORKSHOP COMMITMENT:

- Is their at least one parent committed to attend the parent workshop? YES_____, NO_____.
- Has parent verified that adolescent is committed to attend workshops? YES_____, NO_____.
- Is adolescent aware, that **phones are not allowed at the workshops**? YES_____, NO_____.

HOTEL & TRANSPORTATION:

- At workshops, adolescents share a non-smoking double room with another adolescent same sex.
- PASS Security will be in hotel hallway throughout nights where the adolescents are sleeping.
- Adolescents have scheduled call in time to parents to let them know they have settled in.
- PASS will provide transportation back and forth from home to workshops.
- Adolescents will be under the supervision of the PASS Mentors.

Name of person who referred you _____

Phone Number _____

PASS 2025	PARENTS	ADOLESCENTS	<u>RETURN APPLICATION</u>
July 11-13 (Friday-Sun)	Parent Workshop		Coordinated Care Services Inc.
Aug 7 - 10 (Thurs - Sun)		Adolescent Workshop	Attn: PASS Program Application
Oct 4 (Sat 9a-5pm)		Adolescent Saturday	1099 Jay Street, Building-J, 3 rd Flr,
Oct 18 (Sat 9a-5pm)	Parent& Adolescent Saturday	Adolescent& Parent Saturday	Rochester, NY 14611.
Dec 4-7 (Thurs - Sun)		Adolescent Workshop	Nmorris@CCSI.ORG
3rd Thur (6:30pm-8pm)	Parent Support Meetings		FAX: (585) 328-5211

(Finalizing Hotel dates, expecting them to be about the same.)

Submit (email, mail or fax) completed application by **June 20th, 2025.**

FOR ADDITIONAL INFORMATION

Videos, and testimonies, go to <https://ccsi.org/Programs/PASS-Program>

Neville Morris at Nmorris@CCSI.org, (585) 341-2230work, (607) 765-5656cell.

Maria D'Aquisto Mdacquisto@CCSI.org (585) 314-1538work, (585) 770-4649 cell

there an Individual Education Plan (IEP) or 504 Plan in place for the applicant? _____

Please describe accommodations or supports currently being provided:

ADOLESCENT LIKES, DISLIKES, FEARS

Adolescent Likes: _____

Adolescent Dislikes: _____

Adolescent Fears: _____

ALLERGIES: Does adolescent have any Allergies: ___ Yes, ___ No. Specify: _____

DIET: Does adolescent require a Special Diet: ___ Yes, ___ No. Specify: _____

SPECIAL NEEDS: Does adolescent have a special need: ___ Yes, ___ No. Specify: _____

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MEDICAL AGREEMENT 2025

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

Adolescent Name: _____ Date of Birth: _____

In the event of an emergency, I/We being parent/guardian of the above adolescent, appoint the PASS Program to act on our behalf in authorizing emergency or otherwise necessary medical, dental, surgical care and hospitalization for the above named adolescent.

PARENT OR GUARDIAN INFORMATION:

Parent Name _____ first, _____ last
Phone _____ Cell, _____ work, _____ Hm

EMERGENCY CONTACTS:

NAME#1 _____, Relationship w/Applicant _____

Address _____

Phone _____, Email _____

NAME#2 _____, Relationship w/Applicant _____

Address _____

Phone _____, Email _____

MEDICATIONS: Does the adolescent take medication: ___ Yes, ___ No. *If yes, please specify below.*

NAME	Mg/Dose	Frequency	When(Morn/Noon/Eve/AsNeed)
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1 _____

2 _____

3 _____

4 _____

5 _____

Can your child administer his/her own medication? ___ Yes, ___ No

Hospitalization Coverage for the above-named youth:

Primary Care Physician: _____ Phone # _____

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):

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PARTICIPANT APPLICATION SECTION 2025

Form - Must be completed by: ADOLESCENT.

*Please print or type

Applicant's Name _____
(last) (middle initial) (first)

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

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 _____
 European American/White Other: _

If bi-racial/other, indicate the group you identify with the most.

List 3 things the program can help to improve that would play a major role in your future life/success.

1 _____

2 _____

3 _____

LIKES, DISLIKES, FEARS

Adolescent Likes: _____

Adolescent Dislikes: _____

Adolescent fears: _____

- Are you aware, that [phones are not allowed at the workshops](#)? YES _____, NO _____.
- There will be time assigned to speak with your parents.

Are you currently involved in any team sports? _____

Are you currently working or Volunteering? _____

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

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SCHOOL – SECTION 2025

SCHOOL INFORMATION

School attending _____

School Counselor _____

School Principal/Administrator _____

Assigned Staff Member/School contact person: _____

Address _____

Phone # _____ Fax # _____

E-mail _____

NOTE FOR SCHOOL ADMINISTRATORS:

Participating adolescents in the PASS Program 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. Adolescent immersion workshops are usually held two times for the program year from Thursday to Sunday-Noon. Time will be assigned for doing homework and the mentors are available to assist where needed. 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:

- If there is any additional information needed for their participation to be excused absence, please notify Mr. Neville B. Morris at (607) 765-5656, 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, PASS Program, <https://ccsi.org/Programs/PASS-Program>

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MENTAL HEALTH PROFESSIONAL 2025.

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

*Please print or type 2025

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

PASS Applicant Name _____

Staff Name _____

Title _____ Credential(s) _____

Agency Affiliation: _____

Address _____

Phone (_____) _____ Best time to call AM PM

PLEASE DESCRIBE THE APPLICANT:

Social Functioning/Interpersonal skills: _____

Please describe applicant's strengths: _____

Does applicant exhibit any behaviors the mentors and staff need to understand? If yes, please describe:

Does applicant have a history of aggressive/assaultive behavior? Yes No If yes,

please describe: _____

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

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MEDIA RELEASE AGREEMENT 2025,

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

*Please print or type

From time-to-time adolescents are in media (photo, video, etc.) taken at PASS events. These Medias are sometimes used in conjunction with the 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. 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 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 PASS Program. I grant the PASS Program the following rights in the use of my child's likeness, voice or materials supplied by me or PASS assigned Affiliate, in a production to be produced by PASS. 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. 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, PASS Program, PASS representatives, their assigns, employees or any person or persons, corporation or corporations, acting under their permission or authority, for whom 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 PASS Program from and against all liability. Except where prohibited, participation in the 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.

I the parent and/or guardian of the adolescent named below, hereby consent that any Media which are taken at 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/Guardian Name _____, Signature _____, Date _____

Adolescent Name _____, Signature _____, Date _____