# NEW PATHWAYS PROGRAM

# PARTICIPANT DATA COLLECTION FORM

**Form ID:** NP-DCF-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Completed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Staff Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## SECTION 1: PARTICIPANT INFORMATION

### Basic Information

**Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** **/**/\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_

**Gender Identity:** ☐ Male ☐ Female ☐ Non-binary ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race/Ethnicity:** ☐ Black/African American ☐ Hispanic/Latino ☐ White ☐ Asian

☐ Native American ☐ Pacific Islander ☐ Multiracial ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Language:** ☐ English ☐ Spanish ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Phone:** (***) -***

**Alternative Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (*) -***

**Email (if available):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Justice System Involvement

**Current Case Status:**

☐ Pre-trial ☐ Post-disposition ☐ Probation ☐ Conditional Release ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Court Docket Number(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Probation Officer (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Information:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Charges (if applicable):**

**Next Court Date:** **/**/\_\_\_\_\_\_\_\_

**Court Location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Justice System Involvement:** ☐ Yes ☐ No

If yes, briefly describe:

## SECTION 2: ASSESSMENT INFORMATION

### Housing Status

**Housing status before program entry:**

☐ Unstable housing/couch surfing ☐ Family home ☐ Foster care ☐ Group home

☐ Residential facility ☐ Homeless ☐ Detention/correctional facility

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Length of housing instability (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Education Status

**Current Educational Status:**

☐ Enrolled in high school ☐ High school graduate ☐ GED ☐ Some college

☐ Dropped out (last grade completed: \_\_\_\_\_\_) ☐ Vocational training

☐ College graduate ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of School (if currently enrolled):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School Contact Person:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Information:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Educational Goals:**

### Employment Status

**Current Employment Status:**

☐ Unemployed ☐ Employed part-time ☐ Employed full-time ☐ In training program

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If employed:**

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Wage: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per ☐ Hour ☐ Week ☐ Month

**Employment History (a brief description of previous jobs):**

**Vocational Skills/Interests:**

### Mental Health and Substance Use

**Previous Mental Health Services Received:** ☐ Yes ☐ No

If yes, please describe:

**Current Mental Health Provider (if applicable):**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Substance Use Treatment:** ☐ Yes ☐ No

If yes, please describe:

**Current Substance Use Treatment Provider (if applicable):**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Medical Information

**Health Insurance:** ☐ Medicaid ☐ Private Insurance ☐ None ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Number (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician (if applicable):**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:**

**Medical Conditions/Concerns:**

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Emergency Contact Information

**Primary Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_***) -***

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_***) -***

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## SECTION 3: INDIVIDUALIZED ASSESSMENT

### YASI Assessment Results

**Date of Assessment:** **/**/\_\_\_\_\_\_\_\_

**Overall Risk Level:**

☐ Low ☐ Moderate ☐ High

**Domain-Specific Risk/Needs Scores:**

DomainRisk LevelPriority Need (Y/N)Notes

Legal History ☐ Low ☐ Mod ☐ High ☐ Yes ☐ No

Family ☐ Low ☐ Mod ☐ High ☐ Yes ☐ No

School ☐ Low ☐ Mod ☐ High ☐ Yes ☐ No

Community/Peers ☐ Low ☐ Mod ☐ High ☐ Yes ☐ No

Alcohol/Drugs ☐ Low ☐ Mod ☐ High ☐ Yes ☐ No

Mental Health ☐ Low ☐ Mod ☐ High ☐ Yes ☐ No

Aggression ☐ Low ☐ Mod ☐ High ☐ Yes ☐ No

Attitudes ☐ Low ☐ Mod ☐ High ☐ Yes ☐ No

Skills ☐ Low ☐ Mod ☐ High ☐ Yes ☐ No

Employment ☐ Low ☐ Mod ☐ High ☐ Yes ☐ No

### Participant Strengths

### Participant Goals (in Participant's own words)

## SECTION 4: PROGRAM PLANNING

### Initial Service Plan Priorities

### Court-Mandated Requirements

### Special Considerations/Accommodations Needed

## SECTION 5: REFERRALS AND COORDINATION

### Current Service Providers

Service TypeAgencyContact PersonPhone/EmailFrequency

### Needed Referrals

Service TypeAgencyReferral DateStatusFollow-up Date

## SECTION 6: CONSENT AND RELEASE

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to participate in the New Pathways Program and authorize Team Resurrection Inc. to collect the information contained in this Form. This information will be used to develop an individualized service plan and may be shared with relevant service providers and court personnel as necessary for program participation.

I further authorize Team Resurrection Inc. to exchange information with the Essex County Family Court, Probation Department, and service providers listed in this Form to coordinate services and report on my progress in the program.

This consent is valid for my participation in the New Pathways Program unless revoked in writing.

**Participant Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** **/**/\_\_\_\_\_\_\_\_

**Parent/Guardian Signature (if under 18):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** **/**/\_\_\_\_\_\_\_\_

**Staff Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** **/**/\_\_\_\_\_\_\_\_

## SECTION 7: FOR STAFF USE ONLY

### Intake Assessment Summary

### Initial Recommendations

### Follow-up Actions and Timeline

**Date of Initial Success Plan Development:** **/**/\_\_\_\_\_\_\_\_

**Date of First Case Review:** **/**/\_\_\_\_\_\_\_\_

**Staff Completing Form:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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