Program Registration Form FY 2026

To be completed for EACH program participant
Adults and Children - PLEASE PRINT CLEARLY

Staff Use Only S

_____ Staff Initials D

☐ Fee waived or reduced
☐ Updated Information

CHECK WHICH PROGRAM YOU ARE REGISTERING FOR:

DATE:___/___/_____

☐ ATLAS ☐ COMPASS ☐ CONNECT ☐ CSLO ☐ EXPRESSIONS ☐ FOOD PANTRY ☐ GDFO ☐ GDJD ☐ HISET ☐ KINSHIP
☐ AGENCY NAVIGATION ☐ MINDFUL TEENS ☐ PACC ☐ PHASES ☐ PCS ☐ REJUVEN8 ☐ TAKE CONTROL ☐ TIPS ☐ VAPE ☐ YES
☐ PARENTING CLASS (Write in Name of Class):

Last Name: _____ **First Name:** _____ **Middle Initial** _____

Preferred Name: _____ **DOB** ____/_____/_____ **Age** _____

Address:_____**Town:**_____ **State:**_____ **Zip:**_____

Email: _____ **Telephone** (_____)_____

Participant Marital Status: ☐ **Single, never married, not co-habitating** ☐ **Married** ☐ **Co-Habitating with Significant Other**
☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Other**_____

For Minors: Parent/Guardian Information required:

Name: _____

Phone: _____

Email: _____

Participant Information

Gender identity: _____

Preferred Pronouns: _____

Are you Employed? Full Time ☐ Part Time ☐ Not Employed ☐
SSDI ☐ Retired ☐

If 18 or older, are you a US Veteran or active US Military? Y ☐ N ☐

Under 18? Is a parent/guardian US Vet or act US Military? Y ☐ N ☐

Do you have any access needs to receive service here at the Upper Room (i.e. Parking, Language, Stairs) ? _____

_____

Race Information

☐ Alaskan Native/Native American
☐ African American/Black
☐ Asian
☐ Caucasian/White
☐ Hispanic/Latino/Latina/Latinx/Latin
☐ Middle Eastern/North African
☐ Native Hawaiian/Pacific Islander
☐ More than one
☐ Other/Not Listed: _____

Is your primary language English? Yes ☐ No ☐

Household Information

(ALL household members - *Including yourself*)

Household Monthly Gross Income: $_____

Total # of Household Members: #_____

How many are age 0-5 #_____

How many are age 6-18: #_____

How many are age 19-59: #_____

How many are over 60 years: #_____

Family Members Eligible for or receive (Check Alll that apply)
Free/Reduced School Meals ☐ TANF ☐ WIC ☐ SNAP ☐

Other Services Received: _____

Medical Insurance Information
(select all that apply):

☐ No Insurance
☐ Plan purchased throug employer/union
☐ Plan that you or another family member buys on your own
☐ Medicare
☐ Medicare plus supplemental
☐ Medicaid or other state program
☐ Dual Eligible (covered by Medicare and Medicaid)
☐ TRICARE (Uniformed services health care)
☐ Unknown
☐ Other: _____

How did you hear about us?

COMPLETE **ONLY** WHEN PAYING FOR A SERVICE OR MAKING A DONATION

Payment for? Donation _____ Program Registration _____ What program?_____

Amount: $ _____ Credit Card # _____ Exp Date ___/____ CVV# _____

Check# _____ Cash Amount: $_____ Signature:_____

Release of Confidential Information

Please list the person(s) enrolling in the program, in box below

Name of Individual/Family to receive services.	Date of Birth (participant)

I/we authorize The Upper Room Program and/or Person (Check all that apply)

- ☐ Adolescent Wellness Programs (Includes, Take Control, Phases, Vape Education and Expressions)
- ☐ Agency Navigator
- ☐ Connect-Parent-child group
- ☐ Greater Derry Juvenile Diversion Program/CSLO
- ☐ Food Pantry
- ☐ Family Wellness Programs includes: Greater Derry Family Outreach (Home Visiting), Connect Parent Child Group, Kinship Navigation and Parent Education courses/workshops and Parent Caregiver Cafe
- ☐ HiSET Program
- ☐ Kinship Navigation-Pasta Program
- ☐ Expressions- teen group to promote connections through activities
- ☐ Rejuvenate Program(includes access to Take Control, Challenge Course, Vape Education and Expressions)
- ☐ Teen Information for parenting Success (For young parents)
- ☐ Atlas *This is a drop in group for teens not intended to replace or act as therapy, but as skills coaching
- ☐ Mindful Teens Groups for teens- (Boundaries, Healthy relationships, teen life etc) w Val Mazzola
- ☐ Compass Youth
- ☐ Specific Staff Name:_____

Please list the agency/individual and contact information in the box below

Contact Name/Agency	Contact Phone	Contact Email

I authorize the disclosure/release of the following information:

☐ Complete Record. Including all service/educational/other records (including information regarding mental health care, and treatment of alcohol or drug misuse).

OR I authorize the release of the following information (select all that apply)

- ☐ Services received and service plan goals
- ☐ Educational Records
- ☐ Legal Records
- ☐ Class attendance/participation dates
- ☐ Coordination and provision of ongoing services and supports, education or treatment.
- ☐ Safety Plan
- ☐ Notes/Reports
- ☐ Mental Health Records
- ☐ Substance misuse information/assessments/plan/education (Please refer to CFR 42 for authorization release
- ☐ Other (specify) _____

_____

The purpose of the disclosure authorized by this consent is for:

- ☐ Services received and service plan goals
- ☐ Other (specify) _____

HIPPA Privacy Authorization Form- Authorizes use or disclosure of Protected Health Information and FERPA standards related to educational records* I (we) understand that the information being released is confidential and cannot be released without my (our) written consent.

**** All individuals under 18 MUST have a parent/legal guardian sign.***

I (we) understand that, generally, my (our) ability to receive services or treatment may not be conditioned on whether I (we) sign this authorization form, but that in certain limited circumstances, I (we) may be denied treatment if I (we) do not sign this authorization form.

I (we) understand that I (we) have the right to revoke this authorization, in writing, at any time. I (we) understand that a revocation is not effective to the extent that past permission was already acted upon, or if any authorization was obtained as a condition of program enrollment or required by insurance coverage and/or insurer has the legal right to contest a claim.

I (we) have read this authorization for Release of Protected Health/Educational Information and understand its contents:

Individual or legal representative Signature. (if signed by legal rep, state relationship to client).

Print Client Name: _____ Date: _____

Client Signature: _____

Print Name Parent/Guardian: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

This release expires at the completion of the program/services, or one year from signing.

Please Read and Initial Here to consent _____ I give The Upper Room, A Family Resource Center permission to publish, in print, electronic or format the likeness or image of myself. I release all claims against The Upper Room, A Family Resource Center with respect to copyright ownership and publication including any claim for compensation to use of the materials.

****During programs and activities, TUR may recognize a class, or program by way of photo ops, for press, social media in the desire to promote positive outcomes of activities. It is not mandatory for anyone to participate.***

Please Read and Initial Here to consent: _____ I understand that I/my child is receiving support form the Upper Room Programs/Staff listed above, and that to provide the highest quality service that the team may convene to offer additional supports and services related to the plan/goals identified. Interdisciplinary services are available/practiced at The Upper Room including mental health support, substance misuse and social emotional support. I agree to this level of wrap around services to attain the highest level of success/outcomes in the program for myself/my child. I understand staff may work in collaboration to create the best plan for me/my child, and that this collaboration may include interns who are placed within the agency, performing services under supervision.

Please Read and Initial here to consent:_____ I understand that I/my child may at times access transportation to attend a program, by initialing I am agreeing to transportation being offered, and I will not hold The Upper Room, or anyone related to the program (Other agencies, towns, schools) liable for any incidents/accidents while using this service.

Please Read and Initial here to consent:_____ I understand that I/my child's information related to SUD is protected by CFR 42, and that DHHS has a specific form to release information related to SUD between agencies. I agree to allow this information to be shared by listed organizations for the purpose of treatment and referral.(Form available by request).

Please Read and Initial here to consent:_____ I understand that non-identified data provided is shared with confidential state databases for the purpose of providing service.

Staff Use Only:

Verbal	Program	Date-Method

PARTICIPANT GUIDELINES

To offer safe, positive services and programs we ask all to consider these as expectations of participation.

- Enter Meeting on time both in person/virtual, complete entire class/course
- Use respectful greetings/dialogs
- Sign into group via attendance sheet or chat USE your own name on ZOOM screen
- Meeting is confidential so respect other people's information, no outside guests please
- Discriminatory/hate language, threatening or derogatory conversation is not tolerated
- All attendees will turn off phones and not use during the group/class/program, students are asked to place phones in safe space during classes and programs
- No videotaping/or snap/tik tok/fb/Instagram or any social media sharing from our programs
- Violence, hitting, swearing at one another is not tolerated
- Laws related to smoking/vaping/substance use and weapons are respected
- Respect of classrooms/break rooms/restrooms/inside and outside
- Using items assigned to your program and not going into classrooms/cupboards or supplies of other programs
- All attendees will be fully dressed
- All in attendance will not participate in activities that could be harmful to self or others while in group/class (substance use/violence/threatening/disruptive)
- If you have something you need to discuss with staff, you can send a message via e mail or chat directly to the attending staff member
- If you are concerned for your information/privacy, please discuss this with staff prior to the start of the meeting to see if you can problem solve a solution
- VIRTUAL MEETING PROTOCOL must be in a seat not in bed

Confidentiality Agreement: All information shared in any program remains confidential unless there is concern about the safety of one of our meeting members or someone else's safety. The Upper Room is required to report concerns about safety and wellbeing and will alert appropriate authorities.

We encourage anyone needing additional support to reach out to the staff member you are working with to address additional support you may need to participate in a program.

VIOLATION OF MEETING protocols could result in disciplinary means, including being excused from the group, terminated from a program, or legal action.

***I Understand that my participation in any program offered at The Upper Room comes with expectations and I agree to follow these said rules. Your initials indicate agreement and understanding in the above mentioned expectations and understanding of the Confidentiality agreement.**

_____ Initial participant _____Initial Guardian (if child under 18) Date:_____