



One packet. Essential information only.

Complete all fields. Enter N/A when a question does not apply.

Weekend Selection

Select all requested weekends:

- | | |
|---|---|
| ☐ Sept. 25-27 - Mindful Living Retreat | ☐ Oct. 23-25 - Fall Harvest Weekend |
| ☐ Nov. 20-22 - Thanksgiving Weekend | ☐ Dec. 18-20 - Winter Wonderland Weekend |

What to Include

Attach current copies when applicable:

- | | |
|---|---|
| ☐ Insurance card | ☐ Medication list and instructions |
| ☐ Seizure / safety protocol | ☐ Behavior support plan |
| ☐ Mobility / transportation instructions | ☐ Other relevant plan |

Quick Review

Before submitting, confirm:

- | | |
|--|---|
| ☐ All sections completed | ☐ Emergency consent signed |
| ☐ Media choice selected | ☐ Medication quantities verified |
| ☐ Changes reported to CNP | ☐ Required attachments included |

Submit to: programs@mycnp.services | Questions: 973-731-1101

1. Participant & Contact Information

Participant First Name	Last Name	Preferred Name

Date of Birth	Age	DDD ID (optional)	Medicaid # (optional)

Street Address	Apt / Unit

City	State	ZIP	County

Participant Phone	Participant Email

Guardian / Primary Caregiver

Guardian / Caregiver Name	Relationship	Legal Guardian? Yes / No

Cell Phone	Alternate Phone	Email

Support Team & Emergency Contact

Support Coordinator	SC Agency	SC Phone

SC Email	Authorized Pickup / Update Contact

Emergency Contact Name	Relationship (Emergency)	Emergency Phone

2. Health & Daily Support

Diagnoses / conditions:

- | | | |
|--|--|--|
| ☐ Autism | ☐ Intellectual disability | ☐ ADHD |
| ☐ Epilepsy / seizures | ☐ Cerebral palsy | ☐ Down syndrome |
| ☐ Learning disability | ☐ Mental health condition | ☐ Other |

Other Diagnosis / Condition**Allergies and Reactions****Diet / Swallowing / Food Restrictions****Seizure History and Protocol****Medical / Adaptive Equipment**

Support Level

Communication:

- | | | | |
|--|---|-------------------------------------|---|
| ☐ Independent (communication) | ☐ Prompts / cueing | ☐ AAC / sign | ☐ Staff interpretation |
|--|---|-------------------------------------|---|

Mobility:

- | | | | |
|---|---|--|---|
| ☐ Independent (mobility) | ☐ Supervision (mobility) | ☐ Walker / cane | ☐ Wheelchair / physical help |
|---|---|--|---|

Personal care:

- | | | | |
|---|---|---|--|
| ☐ Independent (care) | ☐ Prompts (care) | ☐ Partial assistance | ☐ Full assistance |
|---|---|---|--|

Eating:

- | | | | |
|---|---|---|---|
| ☐ Independent (eating) | ☐ Supervision (eating) | ☐ Modified texture | ☐ Feeding assistance |
|---|---|---|---|

3. Positive Support, Safety & Interests

How Participant Communicates Needs, Pain, or Refusal

Known Triggers, Warning Signs, or Challenging Situations

Calming Strategies and Successful Supports

Elopement / Community Safety Concerns and Prevention

Adjustment to New Places, Groups, and Transitions

Strengths & Preferences

Preferred activities:

- | | | |
|-----------------------------------|---|---|
| ☐ Music | ☐ Art | ☐ Dance |
| ☐ Swimming | ☐ Walking / nature | ☐ Cooking |
| ☐ Shopping | ☐ Movies / games | ☐ Sports / community |

Strengths, Goals, Motivators, and Comfort Items

4. Providers, Overnight Routine & Transportation

Providers & Insurance

Primary Physician

Office Phone

Insurance Company

Member ID

Group #

Preferred Hospital

Pharmacy

Pharmacy Phone

Overnight & Personal Care

Bedtime, Sleep Routine, and Overnight Needs

Morning Routine, Hygiene, and Toileting Support

Food Preferences, Sensory Needs, and Comfort Items

Transportation & Money

Vehicle Safety / Transportation Needs

Spending Money Instructions

5. Medication Inventory

Enter N/A if no medication is taken. Attach additional medication pages if needed.

Participant Name (Medication)

Prescription Count

OTC Count

Medication support:

- ☐ No medication
- ☐ Guardian administration
- ☐ CNP staff administration
- ☐ Approved self-administration

Medication	Strength / Dose / Route	Time	Purpose	Qty Sent

PRN Parameters / Special Instructions

Guardian / Participant Signature

Date (Medication)

6. Emergency Medical Authorization

I authorize CNP Community Services and its designated staff to obtain emergency medical evaluation and treatment when reasonably necessary to protect the participant's health or safety. This may include ambulance transportation, hospital evaluation, diagnostic testing, medication, and procedures recommended by licensed medical professionals. CNP will make reasonable efforts to contact the guardian or emergency contact as soon as possible.

Participant Name (Authorization)**Guardian / Representative****Relationship (Authorization)****Emergency Phone (Authorization)****Preferred Hospital (Authorization)****Guardian / Representative Signature (Authorization)****Date (Authorization)****Participant Signature (if applicable)****Date (Participant)****Witness / CNP Representative****Date (Witness)**

Additional Emergency Instructions

Emergency Instructions

7. Media Choice & Final Certification

Media Choice

Participation in services is not conditioned on media consent. Select one option.

☐ YES - CNP may use photos/videos for organizational communications and promotion.

☐ NO - CNP may not use photos/videos for external promotion.

Optional limits:

☐ Internal use only

☐ Printed materials only

☐ Website only

☐ Social media only

☐ No identifying caption

☐ Other restriction

Restriction Details

Family / Guardian Certification

I certify that this information is accurate and complete to the best of my knowledge.

I will notify CNP of medication, health, behavioral, contact, or support changes before attendance.

Final confirmation:

☐ Packet completed

☐ Emergency consent signed

☐ Media choice selected

☐ Insurance card attached

☐ Medication list or N/A

☐ Protocols attached if needed

Participant Printed Name

Guardian / Representative Printed Name

Guardian / Representative Signature (Final)

Date (Final)

CNP Staff Review

Date (Staff)