

**Alexander Youth Network**  
**Adolescent Substance Abuse Program**  
**309 Concord Street**  
**Greensboro, NC 27406**  
**Contact Info: [smitchell02@aynkids.org](mailto:smitchell02@aynkids.org)**  
**Phone: (336) 542-0868 or Fax: (800) 975-8101**

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**ADOLESCENT SUBSTANCE ABUSE PROGRAM**  
**(“ASAP”)**

The ASAP program is designed for adolescents between the ages of 13 and 17 with a primary diagnosis of substance abuse. The program is designed to be completed in a period of four to six months, depending on the client’s progress while in the program.

The ASAP program has 8 male beds in a residential group setting and 2 female beds in a therapeutic foster care setting. In order for clients to be considered for the program, the attached Intake Form must be completed and submitted along with a CCA, school records, and any other clinical information available that may be beneficial to determine the appropriateness of the potential participant for the program. ASAP offers a Day Treatment model for 6 hours per day, 5 days per week along with residential services (5600 Group Supervised Living Moderate). All clients must remain enrolled in their home school under “1H” status with the data manager at their school. We will need proof that this has been done prior to admission. ASAP school staff will keep each client’s attendance record and upon completing treatment all academic information will be sent to their school. We will also need a copy of each client’s class/course schedule. Should your child have an IEP that must also be provided prior to admission into ASAP. Each person admitted must be willing to enter and commit to the program voluntarily. The client must also be willing to suspend gang affiliation and participation while engaged in our substance abuse treatment in our facility.

The program is set up in two locations, one for school and the ASAP group home. There is a collaborative arrangement between the structured day academic setting and ASAP where the ASAP clients receive self-contained educational instruction and substance abuse treatment tailored to each client’s needs.

The program structure entails the clients operating under a daily behavioral management **(point/privilege)** system in addition to being required to complete 7 levels of program criteria before leaving the program as a successful graduate. The program levels incorporate numerous activities that focus on addiction issues. While in the program, clients will have the opportunities to earn home visits. These weekend visits are essential to recovery and maintenance issues of clients. A Licensed Clinical Addiction Specialist (LCAS) offers weekly individual sessions, group therapy and/or psychoeducation groups several times per week. ASAP utilizes the Seven Challenges evidenced based curriculum. Two Seven Challenges groups are held weekly and each resident completes journals as part of their treatment. Treatment also consists of monthly multi-family groups and recreational interventions. We also offer family therapy on an as needed basis. The family must commit to coming to the program and participating in the counseling process. The more the family is invested in the program, the higher the success rate continues to be in the home environment after completion of the program. Monthly CFT meetings are held for each client and parental/guardian participation is required.

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**ADOLESCENT SUBSTANCE ABUSE PROGRAM  
("ASAP")  
GROUP HOME ADMISSION REQUIREMENTS:**

To start the process, please send in the referral packet, Clinical Assessment (w/in 6 months) that identifies primary substance abuse diagnosis, and records that show the issues that are prevalent in the school system. Once the participant is identified to meet criteria and appropriateness for the program, a Person Centered Plan will need to be created or updated to reflect Day Treatment goals. ASAP staff can help with creating measureable goals that fit the participant's diagnosis and areas to work on.

Upon admission the following documents will need to be obtained by ASAP staff:

- **Immunization Records**
- **Birth Certificate (Copy)**
- **Original Medicaid Card**
- **Social Security Card (Copy)**
- **Proof of Guardianship**
  
- **Varies medical documents that include an Over the Counter Medication Approval, Physical, Toxicology Order, and a Written Medication Order if the participant is prescribed any medication. (These documents will be given to the case worker/guardian ahead of time to get completed by a doctor.)**

**A list of personal items will be given to the case worker/guardian before admission.**

**A parent or guardian must accompany client at time of admission to sign Voluntary Admissions Agreement and other required forms. Clients must not be under the influence of a controlled substance or alcohol upon admission to ASAP.**

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**ADOLESCENT SUBSTANCE ABUSE PROGRAM  
("ASAP")  
CHECKLIST AND INTAKE**

Referral Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Sex: Male \_\_\_\_\_ Race: \_\_\_\_\_ SSN#: \_\_\_\_\_

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

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Eyes: \_\_\_\_\_ Hair: \_\_\_\_\_

Citizenship: \_\_\_\_\_ Residing County: \_\_\_\_\_ MCO/LME: \_\_\_\_\_

Name of School: \_\_\_\_\_ Phone # of School: \_\_\_\_\_

School Counselor: \_\_\_\_\_ Retained in School: \_\_\_\_\_

Grade in School: \_\_\_\_\_ Number of times suspended from School: \_\_\_\_\_

Last date attended School: \_\_\_\_\_ Type of School Schedule: \_\_\_\_\_

**Client must bring proof of enrollment as "1H" in their school of assignment at the ASAP intake, if not previously provided during referral process.**

**PARENT/GUARDIAN INFORMATION:**

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

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone (Day): \_\_\_\_\_ Phone (Night) \_\_\_\_\_

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**History of family substance use/abuse:** Yes No  
Please give details if possible

**Additional client information:** History of violence: Yes No  
Please give brief explanation if answered yes:

**History of gang involvement:** Please be honest and thorough in explanation. We need full disclosure for the safety of all clients in our facility. Please include the information on a separate page if necessary.

Current Diagnosis: Axis I-V, in Axis I **substance abuse/dependence should be listed as primary diagnosis along with any other oppositional and/or defiant behavior.**

Current prescribed medications client is taking. Please list and make sure family understands it is imperative that enough medication refills are supplied for the duration of the anticipated time he will remain in ASAP, which is 3-6 months. We must have written dr. orders for each prescribed medication. These forms will be supplied by ASAP staff upon initial referral.

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**ADOLESCENT SUBSTANCE ABUSE PROGRAM  
CHECKLIST AND INTAKE**

**SUBSTANCE ABUSE HISTORY:**

Outpatient: Number of times: \_\_\_\_\_  
(Give dates, locations, diagnosis)

\_\_\_\_\_

\_\_\_\_\_

Inpatient: Number of times: \_\_\_\_\_  
(Give dates, locations, diagnosis)

\_\_\_\_\_

\_\_\_\_\_

Drugs of choice: (1) \_\_\_\_\_ (2) \_\_\_\_\_

(3) \_\_\_\_\_

Number of days clean: \_\_\_\_\_

Does client need detox? Yes \_\_\_\_\_ No \_\_\_\_\_

Explain: \_\_\_\_\_

DJJDP/DOC Court involvement and is client court ordered? Yes \_\_\_\_\_ No \_\_\_\_\_

Charges: \_\_\_\_\_

Court Counselor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Phone Number: \_\_\_\_\_

E-Mail for referral contact: \_\_\_\_\_

**MEDICAL INSURANCE:**

Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_ Policy # \_\_\_\_\_

Medicaid: Yes \_\_\_\_\_ No \_\_\_\_\_ Medicaid # \_\_\_\_\_

Beginning and ending dates for Medicaid Card: \_\_\_\_\_ to \_\_\_\_\_

**REFERRALS CAN BE MADE BY CALLING (336) 336-542-0868 OR BY FAXING to (800) 975-8101, OR MAILING TO YOUTH FOCUS, INC., 309 CONCORD ST. GREENSBORO, NC 27406**