



Family Service Agency

Strengthening Individuals & Families

YOUTH APPLICATION AND PARENT PERMISSION FORM

| | | | | | |
|---|----------------------|------------------------|---|------------------------|------------------------|
| Child's First Name: | | Middle Name: | | Last Name: | |
| Preferred Name/Nickname : | | Child's Gender: | | Child Date of Birth: | |
| Child's School: | | Grade: | Lunch period: | Student ID (if known): | |
| Parent/Guardian Name: | | Relationship to Child: | Do you have legal custody of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Is there a person who shares legal custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | If yes, are they aware and supportive of the child's enrollment in the YM program?: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If Yes, Name: | | | Phone Number: | | |
| Primary language spoken at home: | | | Other languages used by parent or child: | | |
| What is the child's living situation? <input type="checkbox"/> Two-parent household <input type="checkbox"/> One-parent household (<input type="checkbox"/> Female / <input type="checkbox"/> Male) <input type="checkbox"/> Other relative of child (non-parent) <input type="checkbox"/> Foster Home <input type="checkbox"/> Group Home <input type="checkbox"/> Other _____ | | | | | |
| Home Phone #: | Parent Cell Phone #: | Child Cell Phone #: | Is it okay to text parent? <input type="checkbox"/> Yes <input type="checkbox"/> No Is it okay to text child? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Home Address: | City: | County: | State: | Zip: | |
| Parent/Guardian E-mail: | | | Child E-mail: | | |
| Parent Place of Employment: _____ | | | | | |
| Parent Work Phone #: _____ | | | | | |
| May we contact you (the parent/guardian) at the work number listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Please check the best number and time to contact you (the parent/guardian)? | | | | | |
| Preferred Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work | | | | | |
| Preferred Time of Day: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening | | | | | |
| Emergency Contact Name: | | | Emergency Contact Phone Number: | | Relationship to Child: |
| Nationality/Country of Origin | | | | | |



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|---|--|
| Child's Race/Ethnicity: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other | <input type="checkbox"/> Multi-race (check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____ |
|---|--|

(continued on the next page)

Please mark the appropriate answers below:

1. Family Service Agency's Youth Mentoring receives funding to provide mentors to children who have parent(s) or parent figure (Aunt, uncle, brother, etc) in prison. Does your child have a parent or parental figure in prison at this time? Yes No If yes, please explain: _____

2. Does your child have a parent/caregiver with current or past military experience? Yes No

If yes, please list dates of service: _____

Branch: Air Force Army Marine Corps Navy Coast Guard

Component: Active National Guard Reserve

Is the parent currently deployed? Yes No

If yes, please the date of deployment: _____

Is the parent retired from the military? Yes No

Is the parent separated/discharged (other than retired)? Yes No

Does your child have a parent/caregiver considered fallen, wounded or disabled? Yes No

3. Has your child ever been arrested or involved in the juvenile justice system?

Yes. Please explain: _____

No

4. Within the last year, has your child been in any trouble at school?

Poor Grades

Skipping school/classes

Truant

Behavior problems (Describe: _____)

Has been suspended (Reason for suspension: _____)

Has been expelled (Reason for expulsion: _____)

Sent to an alternative school (Reason for school change: _____)

4. Number of people (adults and children) in household: _____

5. Is parent/guardian receiving income assistance? Yes No

6. Is parent/guardian receiving housing assistance (i.e. Section 8, residence in public-housing, etc.)?

Yes No If living in a housing development, please list the name: _____



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7. Does your child receive free or reduced lunch? Yes- Free Yes - Reduced No

8. Please check your estimated household income:

- 0-\$10,000 \$10,001-\$15,000 \$15,001-\$20,000 \$20,001-\$30,000
 \$30,001-\$50,000 \$50,001+

9. Does your child receive any of these services?

- Special Education Speech Therapy Tutoring In-school Counseling
 Other Counseling. Please Describe: _____

Household Demographics:

Youth mentoring receives grant funding for providing youth services. As part of the grant requirements we ask for additional household information. Please answer the following as it applies to the **household and primary household/guardian.**

Head of Family Name:

First: _____ Middle: _____ Last: _____

Race: ___ American Indian and Alaska Native ___ Asian ___ Black or African American
 ___ Multi-Race (any 2 or more) ___ Native Hawaiian and Other Pacific Islander
 ___ Other ___ White

Ethnicity: ___ Hispanic/Latino ___ Non-Hispanic/Latino

Primary Language: ___ Arabic ___ Chinese ___ English ___ French ___ German ___ Italian
 ___ Other ___ Russian ___ Sign Language ___ Spanish

Birth Date: ___/___/___ **Social Security Number** _____ - _____ - _____

Education: ___ 0-8 Grade ___ 9-12 (Non Grad) ___ HS Diploma/GED ___ 12+
 Some Post-Secondary ___ 2-4 Yrs. College Grad ___ Graduate or Other Post-Secondary School

Military Status: ___ Active Military ___ None ___ Veteran

Disabled: ___ No ___ Yes

Work Status: ___ Employed Full-Time ___ Employed Part-Time ___ Migrant Seasonal Farm Worker
 ___ Retired ___ Unemployed (More than 6 Months) ___ Unemployed (Not in Labor Force)
 ___ Unemployed (6 Months or Less)

Unable to Work Reason (if applicable): ___ Caregiver ___ Disabled ___ Senior ___ Transportation

Farmer: ___ No ___ Yes ___ Migrant ___ Seasonal

Health Insurance: ___ None ___ Direct Purchase ___ Employment Based ___ Medicaid
 ___ Medicare ___ Military Health Care ___ State Children's Health Insurance Program ___ State
 Health Insurance for Adults



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Family Characteristics:

Family Type: Single Person Single Parent 2 Adults No Children 2 Parent Family
 2 or More Related Adults with Children 3 or More Adults No Children
 Non Parent Adult(s) with Children Foster Parents Multigenerational Household
 Other _____

Housing Type: Own Rent not subsidized Subsidized Rent Institutional
 Group Home Homeless Unsheltered Homeless Sheltered Other _____

Monthly Housing Cost: \$ _____ Recently Sheltered (Y / N)

If Homeless:

Reason _____

Nature of Homelessness:

Chronically Homeless Imminently at Risk of Becoming Homeless Literally Homeless
 Precariously Housed & at Risk of Becoming Homeless

Dwelling Type (do not answer if homeless): Single Family Multiple Units (# of unit's 2-4
 5-10 11 or more) Mobile Home Single Room Occupancy

Additional Household Member #1: First Name: _____ Last Name: _____
 Birth Date: ___/___/___ Social Security Number ___-___-___

Additional Household Member #2: First Name: _____ Last Name: _____
 Birth Date: ___/___/___ Social Security Number ___-___-___

Additional Household Member #3: First Name: _____ Last Name: _____
 Birth Date: ___/___/___ Social Security Number ___-___-___

Child #1: First Name: _____ Last Name: _____ Birth Date: ___/___/___
 Social Security Number ___-___-___

Child #2: First Name: _____ Last Name: _____ Birth Date: ___/___/___
 Social Security Number ___-___-___

Child #3: First Name: _____ Last Name: _____ Birth Date: ___/___/___
 Social Security Number ___-___-___

Child #4: First Name: _____ Last Name: _____ Birth Date: ___/___/___
 Social Security Number ___-___-___



13. How would you describe the best mentor for your child?

We will make every effort to honor your preferences for your child's mentor. FSA's Youth Mentoring does not discriminate on the basis of race, ethnicity, gender, marital status, sexual orientation, or religion. [If applicable: Youth Mentoring also matches boys with female volunteers when there is a lack of male volunteers available].

14. Is there anything else we need to know before matching your child with a Mentor?

15. Do you anticipate any significant life changes over the next year or have you had any in the past year (i.e. moving, child changing schools, etc.)?

16. Does your child have any medical conditions (including food allergies) that might affect him or her participating in activities with a Mentor?



Parent Report on the Child

Child: _____ Parent: _____

Youth Mentoring Staff: _____ Date: _____

INSTRUCTIONS:

This form is used to report the child we have enrolled in our program who will be mentored.

The following definitions are offered to clarify the items on the reverse side of this form. Note that these items are somewhat general. You're encouraged to report on your own specific observations within the general meaning of these definitions. Any questions should be referred to FSA Youth Mentoring staff.

GOAL AREA #1: CONFIDENCE

- 1) Self confidence - *A sense of being able to do or accomplish something.*
- 2) Able to express feelings - *Is able to reveal, talk about, or discuss feelings.*
- 3) Can make decisions - *Thinks before acting and is aware of consequences of behavior.*
- 4) Has interests or hobbies - *Pursues activities such as reading, sports, music, computers, etc.*
- 5) Personal hygiene, appearance - *Dresses appropriately and keeps self neat and clean.*
- 6) Sense of the future - *Knows about educational and career opportunities.*

GOAL AREA #2: COMPETENCE

- 7) Uses community resources - *Partakes in service activities, libraries, recreation, church/other faith-based activities.*
- 8) Uses school resources - *Uses the library, guidance counselors, tutorial centers.*
- 9) Academic performance - *Makes good grades or improves grades.*
- 10) Attitude toward school - *Is positive about going to school and about what can be learned.*
- 11) School preparedness - *Completes homework and other assignments.*
- 12) Classroom participation - *Actively takes part in learning; responds to questions.*
- 13) Classroom behavior - *Pays attention in class; isn't disruptive.*
- 14) Able to avoid delinquency - *Refrains from behaviors that are illegal for person of his or her age.*
- 15) Able to avoid substance abuse - *Doesn't use illegal or harmful substances (e.g., drugs, alcohol, tobacco).*
- 16) Able to avoid early parenting - *Doesn't engage in sexual behavior likely to result in early parenting.*

GOAL AREA #3: CARING

- 17) Shows trust toward you - *Isn't reluctant to confide in you, to accept your suggestions.*
- 18) Respects other cultures - *Doesn't stereotype or put down other ethnic, racial, language, or national groups.*
- 19) Relationship with family - *Interacts well with other family members.*
- 20) Relationship with peers - *Interacts well with persons of own age.*
- 21) Relationship with other adults - *Has good interactions with other adults who are not family members.*

(continued on the next page)



Parent Report on the Child (cont'd)

We would like you to describe your child in the following areas, using the rating system of Well Above Average (for children the same age as your child), Above Average, Average, Below Average, Well Below Average. The definitions for each Please check one box in each row.

CONFIDENCE

- 1. Self-confidence Well Above Average Average Below Average
- 2. Able to express feelings Well Above Average Average Below Average
- 3. Can make decisions Well Above Average Average Below Average
- 4. Has interests or hobbies Well Above Average Average Below Average
- 5. Personal hygiene Well Above Average Average Below Average
- 6. Sense of the future Well Above Average Average Below Average

COMPETENCE

- 1. Uses community resources Well Above Average Average Below Average
- 2. Uses school resources Well Above Average Average Below Average
- 3. Academic performance Well Above Average Average Below Average
- 4. Attitude toward school Well Above Average Average Below Average
- 5. School preparedness Well Above Average Average Below Average
- 6. Class participation Well Above Average Average Below Average
- 7. Classroom behavior Well Above Average Average Below Average
- 8. Able to avoid delinquency Well Above Average Average Below Average
- 9. Able to avoid substance abuse Well Above Average Average Below Average
- 10. Able to avoid early parents Well Above Average Average Below Average

CARING

- 1. Show trust toward you Well Above Average Average Below Average
- 2. Respects other cultures Well Above Average Average Below Average
- 3. Relationship with family Well Above Average Average Below Average
- 4. Relationship with peers Well Above Average Average Below Average
- 5. Relationship with other adults Well Above Average Average Below Average

For Agency Use

| | | |
|--|--|--|
| Match ID: _____ | Date Completed: _____ | Length of match when administered: _____ (Specify in months/years) |
| Age: _____ | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Program: <input type="checkbox"/> Community-Based <input type="checkbox"/> Lunch Buddies <input type="checkbox"/> After School |
| Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other | | |



PARENT CONSENT FORM

By signing below, I give permission:

1. For my child to participate in Family Service Agency's Youth Mentoring program;
2. To have my child participate in an enrollment interview conducted by FSA Youth Mentoring staff and complete questionnaires throughout his/her time in the program containing questions about school, home life, and personal interests;
3. For the exchange of information between FSA's Youth Mentoring and my child's school as it pertains to his/her match and attendance, performance and/or behavior in school;
4. For his/her school to provide social, attendance, and academic information about my child to FSA's Youth Mentoring (e.g. report cards, attendance, behavior reports and/or special education information);
5. For my child and I to complete a questionnaire containing questions about peer relationships, feelings about school, grades, educational expectations, parental relationships and attitudes toward risky behaviors ;
6. To have my child talk with a FSA Youth Mentoring staff person about personal safety;
7. For FSA's Youth Mentoring staff to provide contact information to the volunteer for the purpose of contacting my child;
8. For any duly designated representative of FSA's Youth Mentoring to secure necessary medical, hospital and/or surgical attention for my child;
9. I further state that I will not hold Family Service Agency of DeKalb County, or any of their officers, employees or volunteers liable for giving such consent.

I understand that the program is not obligated to match my child with a volunteer and that as part of the enrollment process I may be asked to provide additional information. I understand that the information I provide in the enrollment process will be kept confidential, unless disclosure is required by law and with exceptions noted. I understand that incidents of child abuse or neglect, past or present, must be reported to proper authorities. I understand that certain relevant information about my child will be discussed with the volunteer who is a prospective match (i.e. demographic information, information relevant to volunteer preferences, and information shared in my child's in-take interview).

I certify that all of the information on this form is true and correct and that all income is reported. I understand this information is being given for the purpose of grant reporting, that the information on this application may be verified, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws. I understand this information will not affect my qualification for the program.

I do hereby release the organization and its employees, agents, members, volunteers and all other persons on its behalf from any and all liability for any damage or injury which such child might sustain while participating in said program and activities, including but not limited to any liability to any right of action that may occur to such child directly, or to me as his/her guardian. I understand that this information may be shared with the school or with partnership agencies when applicable.

I understand that if my child is being matched in a community or site-based program, then transportation of my child with his/her mentor will be pre-arranged between myself, my child and his/her mentor. I understand that Family Service Agency has completed and approved the volunteer's ability to transport my child based on their acceptance as a volunteer. I further understand it is my responsibility to verify said acceptance prior to transportation.

(continued on the next page)



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If my child is matched with a Mentor, I agree to support my child’s match by reviewing the program and safety information given to me by FSA’s Youth Mentoring program, communicating with FSA’s Youth Mentoring staff at least once per month for the 1st year of the match and once every other month for the subsequent years after, for the duration of the match relationship. I will immediately report any concerns I might have to the school or FSA’s Youth Mentoring staff. Failure to maintain contact with FSA’s Youth Mentoring staff will result in suspension or termination of the match.

This authorization shall be effective and continually in force, to the extent permitted by law, from the date of this authorization until revoked by the parent/guardian with written notice.

Parent/Guardian Signature: _____ **Date:** _____

Publicity Release

Family Service Agency of DeKalb County frequently uses photographs of local matches to market the program. I hereby _____ **DO** _____ **DO NOT** give my permission for Family Service Agency to photograph my child for use at the Family Service Agency office, in newspapers, on social media, video (like or not limited to: YouTube, FSA website) or any other media for the purposes of publicity or marketing.

Parent/Guardian signature: _____ **Child’s Name:** _____



Child Medical Information

This is to be used in the event of illness or physical injury to my child during any activity of Family Service Agency's Youth Mentoring program.

I, _____, hereby authorize any duly designated representative of FSA's
 (Parent / Guardian)

Youth Mentoring program to secure necessary medical, hospital and/or surgical attention for my
 child, _____. I further state that I will not hold Family Service
 (Child's full name)

Agency of DeKalb County, or any of their officers, employees or volunteers liable for giving such consent. If practical under the circumstances, these medical services are to be performed by:

Physician: _____ Phone #: _____

If this physician is not available, I hereby give permission for any licensed medical doctor or licensed paramedic to perform any and all necessary medical procedures.

The health insurance company or agency responsible for payment of the child's medical expenses is:

Medicaid Card #: _____

In case of emergency, please notify:

(1) _____
 Name Phone # Relationship to child:

 Address City State Zip

or

(2) _____
 Name Phone # Relationship to child:

 Address City State Zip

 Signature

 Print Name

 Date

 Witness / FSA Youth Mentoring Staff

Release of information Disclosure:

We ask parents to sign the Release of Information to help us to better support you, the family, and children in the program. This includes contact information should we lose contact with you for some reason, school attendance, behavior/office referrals, schedule, family living situations and IEP. The purpose of this release is not to obtain a copy of the IEP. This release is to allow us to talk with you and the school regarding topics that are covered through an IEP. As we develop match goals between your child and the mentor, there is the potential for the mentor to influence academic success. Understanding IEP goals, assists us in developing goals for the match that support academic success. **This release is required for lunch buddies in order for us to coordinate the match meetings with your child's school.**



Authorization to Release Information

Client Name: _____ **Date of Birth:** _____
Address: _____ **Phone:** _____
City, State, Zip: _____

I hereby give consent to Family Service Agency of DeKalb County, 1325 Sycamore Rd, DeKalb IL 60115 815-758-8616 to release and/or exchange protected mental health information and/or program information concerning the above named client in written, oral or electronically to the following person or entity:

School, Agency or Individual: _____
 Address, City, State, Zip: _____
 Phone: _____ Fax: _____

Information to be released for the following purpose: Student Progress _____ Health care use _____ Legal use _____
 _____ Personal use _____ Referral _____ Continuity of care Other: **Needs assessment; Program participation**
 Treatment date(s): _____ to _____ Expiration date: _____
Child's Date of Birth One year from today's date One year from today's date

Type of Information (Check all that apply):

Youth Mentoring Senior Services Treatment Plan Dates of Service
 Discharge Summary Treatment Progress/Notes Medication information Client history
 Mental Health Intake/assessment Other (specify) **attendance, academic records, contact information, behavior / office referrals, schedule, family living situation, match activities, Individualized Education Program (IEP)** HIV Documentation (Client must initial) _____ Substance Abuse (client must initial) _____
 Children's Advocacy Center: Forensic Interview Disclosure and Services*

*Please note that if Children's Advocacy Center: Forensic Interview Disclosure and Services is selected, this only permits discussion of interview with mental health or medical professionals. Records from the Children's Advocacy Center will not be released without a judge signed subpoena.

I understand that:

- I have the right to obtain a copy of my own protected health information
- I have the right to revoke this authorization at any time, I must do so in writing to the medical records department, I may not revoke for information that has already been authorized and disclosed
- Re-disclosure of information is prohibited without written consent, that being stated, Family Service Agency cannot prevent an entity to which it is disclosing to from re-disclosing the information on their own accord
- Authorizing to disclose protected health information is voluntary and not required for treatment, payment, or benefits
- Form must be filled out in its entirety for request to be honored.
- Fees may be charged for records per all laws applicable to release of protected health information.
- My record may contain information pertaining to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)

 Client Signature (Client 12 years of age or over) Date Parent or Guardian signature Date
Clients age 12 to 17 must sign in addition to the parent or guardian.

 Relationship to client

 Witness Date