



DYCD Application for 2017-2018 School Year

One World at P.S. 102

Enrollment Packet Overview

Please answer all the questions below to help us provide quality services. Those marked with an asterisk (*) are optional. If there is a question that you do not understand, please seek help.

This enrollment packet will allow you or your child to be enrolled in this program. The information captured through this form will help the program plan to provide a safe and healthy environment, and provide appropriate services. Enrollment packet sections:

- Applicant's Information
- Participant Background (page2)
- Participant Safety and Health (page 3)
- Participant Pick- up
- Parent/ Guardian Consent
- Emergency Medical Treatment
- HeartShare Media Consent Form
- Sibling Inquiry Form

Please make sure you (Parent/Guardian) sign on pages 4, 5, 6, 7, and 8.

Return your completed application either hard copy, fax or email to HeartShare at nada.arkadan@heartshare.org, or fax: 718-567-2367 no later than **Wednesday, September 6, 2017.**

Application Lottery will be on **Thursday, September 7, 2017** at 4pm in the auditorium.

If you have any questions please contact Ms. Nada at 718-567-2365 by phone before August 18 or by email at any time.



WELCOME! The following application will allow you or your child to be enrolled in this program. One application will be accepted for each person. Submission of an application does not guarantee eligibility or enrollment in the program. If accepted, the program will be at no cost to the participant. The following application items are collected for informational and program planning purposes: *Sex, Race, Ethnicity, Income, Household Type, Language, Population Type, Health Insurance.* Your responses will not impact your status in receiving benefits or services.

Applicant's First Name										Applicant's Last Name										Middle Initial	

Applicant's Primary Address (Number and Street)																		Apt. #		

Borough												Zip Code			

Applicant's (or Parent/Guardian's) Cell Phone Number								Applicant's (or Parent/Guardian's) Home Phone Number							

Applicant's Email Address												Applicant's Preferred Method of Contact			
												<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Home Phone	<input type="checkbox"/> Email	<input type="checkbox"/> Other: _____

Emergency Contact Name								Emergency Contact Phone Number							

Applicant's Date of Birth (MM/DD/YEAR)			Applicant's Sex		Applicant's Ethnicity			Applicant's Race				
			<input type="checkbox"/> Female	<input type="checkbox"/> Male	(Select One)			(Select all that apply)				
					<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Non-Hispanic or Latino	<input type="checkbox"/> Black or African-American	<input type="checkbox"/> Native Hawaiian & Other Pacific Islander	<input type="checkbox"/> White or Caucasian	<input type="checkbox"/> American Indian & Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Other: _____

How well does the Applicant Speak English? (Select One)	Applicant's Primary Language						Other Languages Spoken by Applicant																																																														
	(Select One)						(Select All That Apply)																																																														
<input type="checkbox"/> Fluent/Very Well	<input type="checkbox"/> English	<input type="checkbox"/> Hebrew	<input type="checkbox"/> Portuguese	<input type="checkbox"/> English	<input type="checkbox"/> Hebrew	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Well	<input type="checkbox"/> Albanian	<input type="checkbox"/> Hindi	<input type="checkbox"/> Romanian	<input type="checkbox"/> Albanian	<input type="checkbox"/> Hindi	<input type="checkbox"/> Romanian	<input type="checkbox"/> Not Well	<input type="checkbox"/> Arabic	<input type="checkbox"/> Hungarian	<input type="checkbox"/> Russian	<input type="checkbox"/> Arabic	<input type="checkbox"/> Hungarian	<input type="checkbox"/> Russian	<input type="checkbox"/> Not Well at All	<input type="checkbox"/> Bengali	<input type="checkbox"/> Italian	<input type="checkbox"/> Spanish	<input type="checkbox"/> Bengali	<input type="checkbox"/> Italian	<input type="checkbox"/> Spanish	<input type="checkbox"/> Chinese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Chinese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Tagalog	<input type="checkbox"/> French	<input type="checkbox"/> Korean	<input type="checkbox"/> Turkish	<input type="checkbox"/> French	<input type="checkbox"/> Korean	<input type="checkbox"/> Turkish	<input type="checkbox"/> Fulani	<input type="checkbox"/> Kru/Ibo/Yorba	<input type="checkbox"/> Urdu	<input type="checkbox"/> Fulani	<input type="checkbox"/> Kru/Ibo/Yorba	<input type="checkbox"/> Urdu	<input type="checkbox"/> German	<input type="checkbox"/> Mande	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> German	<input type="checkbox"/> Mande	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Greek	<input type="checkbox"/> Punjabi	<input type="checkbox"/> Yiddish	<input type="checkbox"/> Greek	<input type="checkbox"/> Punjabi	<input type="checkbox"/> Yiddish	<input type="checkbox"/> Gujarati	<input type="checkbox"/> Persian	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Gujarati	<input type="checkbox"/> Persian	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Hatian/Creole	<input type="checkbox"/> Polish	<input type="checkbox"/> Polish	<input type="checkbox"/> Hatian/Creole	<input type="checkbox"/> Polish	<input type="checkbox"/> Polish



For all the next set of questions, **HOUSEHOLD** is defined as: any individual or group of individuals (family or non-family members) who are living together as one economic unit. **INCOME** is defined as the total annual gross income (before taxes) of all family and non-family members 18+years' old *living* within the household. All sources of income must be counted from all persons in the household based on the last 12 months.

Household Size

- One Six Eleven Sixteen
 Two Seven Twelve Seventeen
 Three Eight Thirteen Eighteen
 Four Nine Fourteen Nineteen
 Five Ten Fifteen Twenty

Total gross annual income in last 12 months

- \$0 \$1 to \$11,880 \$11,881 to \$16,020 \$16,021 to \$20,160
 \$20,161 to \$24,300 \$24,301 to \$28,440 \$28,441 to \$32,580 \$32,581 to \$36,730
 \$36,731 to \$40,890 \$40,891 to \$50,000 \$50,001 to \$60,000 \$60,001 to \$70,000
 \$70,001 to \$80,000 \$80,001 to \$90,000 \$90,001 to \$100,000 \$100,000+
 Decline to answer

Head of Household Type: (Select all that apply)

- Single Parent – Female Two Adults – No Children Single Person – No children
 Single Parent – Male Two Parent Household Other

Applicant's housing type: (Select One)

- Own Rent Shelter
 Homeless Runaway Youth Other: _____
 NYCHA: Development _____

Sources of Applicant's Household Income: (Select all that apply)

- Employment Wages Unemployment Wages
 Supplemental Nutrition Assistance Program (SNAP) Temporary Assistance for Needy Families (TANF)
 Social Security Supplemental Security Insurance (SSI)
 Workers' Compensation Safety Net/Home Relief
 Pension

Applicant's School Type (Select One)

- Full-Time Student Part-Time Student Not in School

Current Grade (Select One)

- Elementary School: Pre-K K 1st 2nd 3rd 4th 5th Middle School: 6th 7th 8th High School: 9th 10th 11th 12th
Community College: 1st yr. 2nd yr. 3rd yr. 4th yr. 5th yr. 6th yr. + College/University: Freshman Sophomore Junior Senior
Other: High School Equivalency (HSE) Vocational/Trade School Foreign Degree

Is applicant or is any member of the household (0 – 64 years of age) covered by Medicare, Medicaid, Child Health Plus, or private medical insurance? (Select One)

- Yes No

Is the applicant any of the following: (Select all that Apply)

- Disabled Parent/Guardian Foster Care Participant
 Offender/Justice Involved Veteran Decline to answer

If no, do you want to be contacted by someone else with information about signing up for public health insurance programs? (Select One)

- Yes No

If yes, how would you like to be contacted about this issue? (Select One)

- Email Phone U.S. Mail Via provider

Would you be interested in registering to vote? (Select One)

- Yes No

Please answer all the COMPASS specific questions below to help us provide quality services. Those marked with an asterisk (*) are mandatory. If there is a question that you do not understand, please seek help. You can speak with a worker at the CBO that operates the program or call 311 and request the DYCD Youth Hotline. DYCD also has a website www.nyc.gov/dycd and can be followed on Facebook and Twitter for additional information on DYCD services.

School Information

- Student ID/OSIS: _____
- School Type: Public Charter Private Other
- School Name: _____
- School Address: _____ Borough: _____ Zip Code: _____

Participant Safety: If there is an emergency, please contact the following individuals.

①

NAME*		RELATIONSHIP TO PARTICIPANT:
Pick Up*	<input type="checkbox"/> This person may pick up my child.	Write down all numbers and circle the best number to call in case of an emergency: Contact <input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____ <input type="checkbox"/> Work _____ <input type="checkbox"/> Email* _____ <input type="checkbox"/> No Email
Address	_____	
City, State	_____	
Zip Code	_____	

②

NAME*		RELATIONSHIP TO PARTICIPANT:
Pick Up*	<input type="checkbox"/> This person may pick up my child.	Write down all numbers and circle the best number to call in case of an emergency: Contact <input type="checkbox"/> Home _____ <input type="checkbox"/> Cell _____ <input type="checkbox"/> Work _____ <input type="checkbox"/> Email* _____ <input type="checkbox"/> No Email
Address	_____	
City, State	_____	
Zip Code	_____	

Participant Health Information: Please check any of the following that pertain to the participant. Many needs or health challenges can be accommodated and may not limit enrollment in the program.

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Allergies to food | <input type="checkbox"/> Behavioral/Emotional Issues | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Allergies to medications | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Individualized Education Plan | <input type="checkbox"/> Disabilities |
| <input type="checkbox"/> Allergies other (please Specify) | <input type="checkbox"/> Congestive Illness (e.g., heart murmur/disease, blood pressure) | <input type="checkbox"/> Obesity | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Corrective Devices (e.g., crutches, hearing aid, eye glasses) | <input type="checkbox"/> Other (please specify) | |

Check off all that apply.

- Does your child have special health care needs that require treatment and/or medication?
 - Does your child take medication for any condition or illness?
 - Updated Medical Information on File:
 - Are there any activities your child cannot participate in? (If so, please specify below)
- Activities your child cannot participate in:
- _____

DYCD PROGRAM

☞ This section is only for parents enrolling their children. ☞

Pick-up/Dismissal Information:

My child has permission to walk home alone at dismissal. Yes No

My child MAY NOT be picked up by: _____

Signatures:

To the best of my knowledge the information above is true. I agree to its verification and understand that falsification may be grounds for termination of service. Information provided may be used by the City of New York to improve City services or to access additional funding.

I have completed this application for my child.

Parent/Guardian: _____
(Print) (Sign) (Date)

I have completed this application for myself.

Applicant: (18 and older) _____
(Print) (Sign) (Date)

Organization: _____

Intake Specialist/Staff: _____ Date: _____

Parent/Guardian Consent

The Department of Youth and Community Development (DYCD) provides funding for this program as part of its mission to help you assist your child reach his or her full potential. Many of our programs are run by community based organizations. We work to make sure the services you and your children receive are of the highest quality. DYCD is requesting your permission to allow us to collect information we need on your child, their participation and the quality of the services provided.

Consent to Collect and Share Student Information

What information from your child's student records is DYCD requesting?

We are requesting your permission for the NYC Department of Education (DOE) to share personally identifiable information from your child's student records with DYCD. The information we would like to collect consists of biographical and enrollment information (specifically consisting of your child's name, address, date of birth, student identification number, grade, school(s) attended and transfer, discharge, and graduation data about your child); data concerning your child's school attendance (including number of days attended and absences); and academic performance data (including your child's results on state and national exams, credits earned, grades, promotion and retention status, and fitnessgram score); and data related to any disciplinary actions taken against your child (including number and type of suspensions).

We are requesting to collect the information listed above about your child on a past, present and future (i.e., ongoing) basis.

We are also requesting your permission for DYCD to share information we collect on the enrollment form from you and/or your child with DOE staff. The information includes registration information, student's interests and challenges, type of program enrolled-in and frequency of participation. This information will be used to help the school and community organization work together to meet you and your child's needs.

Who will see my child's information and how will it be safeguarded?

The only people who will see your child's individual information are DYCD and DOE staff who manage the data systems and prepare research reports and program analyses. The limited number of DYCD staff identified to receive personal information is screened, and provided extensive training to follow strict guidelines on protecting the confidentiality of information that would personally identify you or your child. Personally identifiable information collected from student records will only be shared electronically between DOE and DYCD and will be secured and protected in the DYCD data base. Personally identifiable information will not be shared with any community based organizations or their staff members.

We will not use your name or your child's name in any published report. While we request your consent, your responses to the below requests will not affect your child's participation in DYCD sponsored programs.

Please check Yes or No to each of the following statements:

- I understand why DYCD is asking my permission to access the information listed above from my child's student records, and I give permission to DOE to share that information with DYCD on an ongoing basis.
 Yes, I give my permission No, I do not give my permission
- I understand why DYCD is asking my permission to share information about my child collected by DYCD with DOE staff and I give my permission to DYCD to share information with DOE on an ongoing basis.
 Yes, I give my permission No, I do not give my permission

Student/Applicant Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Additional Parent/Guardian Name: _____

Additional Parent/Guardian Signature: (optional) _____



Consent for Photo/Videotaping and Use of Youth Work

Please be aware that sometimes staff, photographers, newspapers, television reporters, media representatives and public relations personnel may be present during program activities and special events, both at off-site events and events taking place in the usual program location. In some cases, they may photograph, videotape, interview or otherwise record children who participate in these events. The resulting images, videos and interviews may be used solely for non-profit, non-commercial purposes in printed and electronic media such as brochures, books, print and email newsletters, DVDs and videos, websites, social media and blogs (collectively, "Media"). These images, videos and interviews may be used by DYCD and third-party organizations that collaborate with DYCD, without compensation and without further approval, solely for non-profit, non-commercial purposes.

If, in the course of participating in program activities or special events, any original work is created by a participant, DYCD may use the created work in any and all Media to promote the program or for other informational, non-profit and non-commercial purposes, without compensation and without further approval.

- I understand my child may be photographed, interviewed or otherwise recorded during program activities and special events and give permission for my child to be photographed, interviewed or otherwise recorded solely for non-profit, non-commercial purposes of the program.
 Yes, I give my permission No, you do not have permission
- I understand that my child's work may be used in materials that promote programs, solely for non-profit; non-commercial purposes of the program.
 Yes, I give my permission No, you do not have permission

Consent for Emergency Medical Treatment

I give authority to the Program Agency's staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible. I understand that every effort will be made to contact me before and after medical care is provided.

Yes, I give permission No, I do not give permission

Consent Statement

I the undersigned, certify that I have reviewed all the above consent statements and indicated my wishes. I understand that consent is voluntary and I can withdraw it in writing at any time.

Student/Applicant Name

Student Signature (if 18 or older)

Parent/Guardian Name

Parent/Guardian Signature Date

Additional Parent/Guardian Name (optional)

Additional Parent/Guardian Signature Date

DYCD PROGRAM



HeartShare
HUMAN SERVICES OF NEW YORK

Public Affairs Department
12 MetroTech Center, 29th Fl.
Brooklyn, NY 11201
www.heartshare.org

MEDIA CONSENT FORM

I/We, _____, residing at _____

_____, am/are the parent(s)/guardian(s) of
_____ (referred to as "my child"). We participate in

programs and activities with HeartShare Human Services of New York and its affiliates –
HeartShare Education Center (The HeartShare School), HeartShare Wellness and HeartShare St.
Vincent's Services.

I/We hereby consent that photographs and video taken of my child, on behalf of HeartShare Human
Services of New York, may be used for the following purposes: *(select all that you grant permission for)*

- HeartShare Annual Report
- HeartShare newsletters, including InSights and Heart to Heart
- HeartShare and HeartShare affiliate websites
- Social media websites, including, but not limited to, Facebook, Instagram, Tumblr, Twitter, and YouTube.
- Press releases from HeartShare for print or broadcast media. These may include newspaper or magazine articles, radio and television interviews and/or features, publications
- Advertisements for HeartShare
- Information materials, such as, but not limited to, agency brochures, videos, and photo and audiovisual information displays
- Everyday Heroes Program

or

- Only internal program use (i.e. classrooms, hallways); do not use externally

I/We consent to the use of our names and association with HeartShare for the foregoing purposes. I/We give this authorization without incurring any financial or moral obligations to my child or myself/ourselves and without any remuneration to my child or myself/ourselves.

Signature(s): _____ Date: _____
 Witness: _____ Date: _____

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS
 (This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM _____

CHILD'S LAST NAME _____ FIRST NAME _____ BIRTHDATE / / SEX M F

Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

Place of Employment: Father (Guardian) _____ Phone: _____

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent, Guardian are not available in an emergency, notify:

1. _____ Phone: _____

or 2. _____ Phone: _____

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
 Yes No (If yes, state type of exposure: _____)

HEALTH HISTORY: (Check box if child has had afflictions, give appropriate dates)

- | | |
|--|---|
| <input type="checkbox"/> Rheumatic Fever _____ | Allergies |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Hay Fever _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Poison Ivy, etc. _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Insect Stings _____ |
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Penicillin _____ |
| | <input type="checkbox"/> Other Drugs _____ |
| | <input type="checkbox"/> Food _____ |

Other Past Illnesses _____

Operations or Serious Injuries (Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.) _____

Medication taken _____

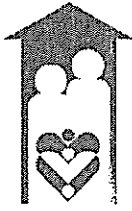
Suggestion from Parent/Guardian _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship _____ Signature _____ Date _____ Tel.# _____





HeartShare

S' VINCENT'S
S E R V I C E S

Child's Name: _____

Current Grade: _____ Current Teacher: _____

GRADE IN SEPTEMBER: _____

Please list ALL siblings that you are enrolling in the after-school program (first and last name)

SIBLING _____ GRADE IN SEPTEMBER: _____

SIBLING _____ GRADE IN SEPTEMBER: _____

SIBLING _____ GRADE IN SEPTEMBER: _____

