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2024-2025 SY

Office Use Only
Date Application Received:
Enrollment Start Date:
Intake Specialist/Staff:
Additional Information:

DYCD Universal Participant Intake: Youth & Adult Application *(Ages 13 & Younger)*

Welcome to the Department of Youth and Community Development (DYCD)! DYCD is a New York City agency that funds programs for youth and families. These programs are operated by Community Based Organizations (CBOs). This form will allow you or your child to apply to a DYCD Comprehensive Afterschool System (COMPASS), Beacon, or Cornerstone youth or adult program. Please complete this form fully and return to the CBO that operates the program. One application will be accepted per person per site. **Submission of an application does not guarantee enrollment in the program**. Further paperwork and information may be required to determine program eligibility. If accepted, program will be **at no cost** to the participant. The following application items are collected for informational and program planning purposes only: *Income, Gender, Race, Ethnicity, Language, Population Type, Household Information and Health Insurance Status.* Responses to these questions will not impact your eligibility to receive services and will not be shared outside of DYCD without the applicant's permission.

Part I: Applicant Information

For the purposes of this application, applicant refers to the person applying to receive services. Select one:

☐ I am completing this application for myself ☑ I am a parent or guardian completing this application for my child

☐ I am a relative/non-relative, completing this application on behalf of the applicant

Applicant's First Name:	**Applicant's Last Name:**	**MI:**

Applicant's Date of Birth (MM/DD/YEAR):	**Applicant's Primary Address** (*Number and Street*):

Applicant's Apt. Number:	**Applicant's City**:	**Zip Code:**

Applicant's Sex at Birth (Select One):

☐ Female
☐ Male
☐ X (not female or male)
☐ Not sure

Applicant's Race (Select all that Apply):

☐ American Indian and Alaskan Native
☐ Asian
☐ Black or African-American
☐ Middle Eastern/North African
☐ Native Hawaiian and Other Pacific Islander
☐ White or Caucasian
☐ Other _____

Applicant's Ethnicity (Select One):

☐ Hispanic or Latinx
☐ Not Hispanic or Latinx

☐ **Applicant lives in a NYCHA Development (please provide name)** _____

Part II: Applicant's (or Parent/Guardian's) Contact Information

Applicant's Contact Information (Student's Contact Info.)

For youth without contact information, skip to the next section to provide parent/guardian contact information

Write down phone numbers for the applicant and check the preferred method of contact:

☐ Home _____ ☐ Cell _____ ☐ No Email

☐ Work _____ ☐ Email _____ ☐ US Mail

Parent/Guardian Information

This section is required for Applicants under 18

Parent/Guardian Name: _____

Write down all phone numbers and check the best number to call in case of an emergency:

☐ Home _____ ☑ Cell _____ ☐ No Email

☐ Work _____ ☐ Email _____

Address: ☑ Same as Applicant	**City:**	**State:**	**Zip Code:**

Emergency Contact Information

At least one emergency contact must be identified

1

Emergency Contact #1 Name:	**Relationship to Participant:** ☑ Emergency contact is parent/guardian of participant

Write down all phone numbers and check the best number to call in case of an emergency:

☐ Home _____ ☑ Cell _____ ☐ No Email

☐ Work _____ ☐ Email _____

Address: ☑ Same as Applicant	**City:**	**State:**	**Zip Code:**

2

Emergency Contact #2 Name:	**Relationship to Participant:** ☑ Emergency contact is parent/guardian of participant

Write down all phone numbers and check the best number to call in case of an emergency:

☐ Home _____ ☑ Cell _____ ☐ No Email

☐ Work _____ ☐ Email _____

Address: ☑ Same as Applicant	**City:**	**State:**	**Zip Code:**

This section is for parents/guardians enrolling their children

Emergency contacts listed in Section II are authorized to pick up the child unless otherwise noted.

The following <u>additional</u> people are authorized to pick up my child:

Name:	**Phone #:**	**Relationship:**
Name:	**Phone #:**	**Relationship:**
Name:	**Phone #:**	**Relationship:**

The following people MAY NOT pick up my child:

Name:	**Name:**	**Name:**

Part III: Applicant's Education/Work Status

Applicant's Education Status (Select One):

☑ Full-Time Student*** ☐ Part-Time Student*** ☐ Not in School****

***If applicant is a *Part-Time Student* or *Full-Time Student*: **Select applicant's current grade** (Select One):
****If applicant is *Not in School:* **Select the last grade completed by the applicant** (Select One):

Middle School: ☐ 6th ☐ 7th ☐ 8th

Applicant's Current Work Status (Select One):

☐ Employed Full-Time	☐ Employed Part-Time	☐ Retired
☐ Unemployed (Short-Term, 6 months or less)	☐ Unemployed (Long-term, more than 6 months)	☐ Unemployed (Not in labor force)
☐ Migrant Seasonal Farm Worker	☑ Not applicable (applicant is under 14 years of age)	

Required for Full-Time Students

Student ID/OSIS:	**School Type:** ☑ Public ☐ Charter ☐ Private ☐ Other _____
School Name:	

School Address:	City:	Zip Code:
46-21 Colden Street	Flushing	11355

Part IV: Health Information

Applicant's Health Information

Please answer the questions below and provide additional details in the space provided.
Many needs or health challenges can be accommodated and may not limit enrollment in the program.

Does the applicant have any allergies? (food, medication, etc.)

☐ No ☐ Yes _____

Does the applicant have asthma?

☐ No ☐ Yes

Does the applicant have special health care needs?

☐ No ☐ Yes _____

Does the applicant take medication for any condition or illness?

☐ No ☐ Yes _____

Are there activities the applicant cannot participate in?

☐ No ☐ Yes _____

Please provide any additional health information details:

☐ **N/A**

Please list any accommodation(s) you are requesting for yourself/the applicant:

☐ **N/A**

Applicant's Health Insurance Status

Does the applicant have health insurance? (Select One):

☐ Yes ☐ No

☐ Decline to Answer

***If yes,* what kind of health insurance does the applicant have?** (Check all that Apply)**:**

☐ Medicaid ☐ Medicare ☐ State Children's Health Insurance Program

☐ Employment-Based ☐ Direct-Purchase ☐ State Children's Health Insurance for Adults

☐ Military Health Care ☐ Decline to Answer

***If you do not have health insurance*, do you want to be contacted by someone else with information about signing up for public health insurance**? (Select One):

☐ Yes ☐ No ☐ Decline to Answer

***If you would like to be contacted about signing up for public health insurance,* what is your preferred method of contact?** (Select One):

☐ Email ☐ Phone ☐ US Mail

☐ Via provider ☐ Decline to Answer

Part V: Additional Applicant Information

How well does the applicant speak English? (Select One):

☐ Fluent/Very well
☐ Well
☐ Not well
☐ Not well at all

Applicant's Primary Language (Select One):

☐ English	☐ Albanian	☐ Arabic
☐ Bengali	☐ Chinese*	☐ French
☐ Fulani	☐ German	☐ Gujarati
☐ Haitian Creole	☐ Hebrew	☐ Hindi
☐ Hungarian	☐ Italian	☐ Japanese
☐ Korean	☐ Kru, Ibo, or Yoruba	☐ Mande
☐ Punjabi	☐ Persian	☐ Polish
☐ Portuguese	☐ Romanian	☐ Russian
☐ Spanish	☐ Tagalog	☐ Turkish
☐ Urdu	☐ Vietnamese	☐ Yiddish

☐ Other: _____

**including Cantonese and Mandarin*

Other Languages Spoken by Applicant (Select all that Apply):

☐ English	☐ Albanian	☐ Arabic
☐ Bengali	☐ Chinese	☐ French
☐ Fulani	☐ German	☐ Gujarati
☐ Haitian Creole	☐ Hebrew	☐ Hindi
☐ Hungarian	☐ Italian	☐ Japanese
☐ Korean	☐ Kru, Ibo, or Yoruba	☐ Mande
☐ Punjabi	☐ Persian	☐ Polish
☐ Portuguese	☐ Romanian	☐ Russian
☐ Spanish	☐ Tagalog	☐ Turkish
☐ Urdu	☐ Vietnamese	☐ Yiddish

☐ Other: _____

☐ Not applicable (only one language spoken by applicant)

**including Cantonese and Mandarin*

Would the applicant like to receive information/ be contacted about registering to vote?** (Select One):

☐ Yes ☑ No

**Applicant is eligible to vote in U.S. federal elections if:
1) You are a U.S. citizen;
2) You meet your state's residency requirements;
3) You are 18 years old. Some states allow 17-year-olds to vote in primaries and/or register to vote if they will be 18 before the general election. Check your state's voter registration age requirements.

Is the applicant any of the following:

Parent/Legal Guardian?	☐ Yes	☑ No
Offender/Justice Involved?	☐ Yes	☑ No
Foster Care Participant?	☐ Yes	☑ No
Runaway Youth?	☐ Yes	☑ No
Veteran?	☐ Yes	☑ No
Active Military Personnel?	☐ Yes	☑ No
An Individual with a Disability?	☐ Yes	☐ No ☐ Decline to answer

***If the applicant is an individual with a disability*, please select disability type(s)** (Select all that Apply):

☐ Cognitive impairment
☐ Hearing-related
☐ Learning disability
☐ Mental or Psychiatric
☐ Physical/Chronic Health Condition
☐ Physical/Mobility Impairment
☐ Vision-related
☐ Other: _____
☐ Decline to Answer

Part VI: Household Information

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 of all family and non-family members 18+years old living within the household.

The applicant lives in a household that is headed by (Select One):

- ☐ Single Parent - Female
- ☐ Single Parent - Male
- ☐ Single Person - No children
- ☐ Non-related adults with children
- ☐ Two Adults – No Children
- ☐ Two Parent Household
- ☐ Multigenerational Household
- ☐ Other: _____

Applicant's Housing Type (Select One):

- ☐ Own
- ☐ Rent
- ☐ NYCHA
- ☐ Shelter
- ☐ Homeless
- ☐ Other Permanent Housing
- ☐ Other: _____

Applicant's Household Size (Select One)**:**

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

Total Household Income in the last 12 Months (Select One):

- ☐ $0
- ☐ $1 to $12,060
- ☐ $12,061 to $16,240
- ☐ $16,241 to $20,420
- ☐ $20,421 to $24,600
- ☐ $24,601 to $28,780
- ☐ $28,781 to $32,960
- ☐ $32,961 to $37,140
- ☐ $37,141 to $41,320
- ☐ $41,321 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

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

- ☐ Employment Wages
- ☐ Childcare Voucher
- ☐ Housing Choice Voucher
- ☐ Permanent Supportive Housing
- ☐ Retirement Income from Social Security
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ WIC
- ☐ Affordable Care Act Subsidy
- ☐ Earned Income Tax Credit (EITC)
- ☐ HUD-VASH
- ☐ Private Disability Insurance
- ☐ Social Security Disability Income (SSDI)
- ☐ Unemployment Insurance
- ☐ Worker's Compensation
- ☐ Alimony or other Spousal Support
- ☐ Employment Tax Credit
- ☐ LIEHEAP
- ☐ Public Housing
- ☐ Supplemental Security Income (SSI)
- ☐ VA Non-Service Connected Disability Pension
- ☐ Other: _____
- ☐ Child Support
- ☐ General Assistance
- ☐ Pension
- ☐ Safety Net/Home Relief
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ VA Service-Connected Disability Compensation
- ☐ Decline to Answer

Part VII: Consents and Signatures

Pick-up/Dismissal Information

This question must be answered for parents/guardians enrolling their children

My child has permission to travel home alone at dismissal:

☐ Yes ☐ No

Consent to Participate

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 and access to those services, and to access additional funding.

If participant is under 18 years old:

Parent/Guardian's Signature	Parent/Guardian: Print Name	Date

Consent for Emergency Medical Treatment

If participant is under 18 years old:

My child is enrolled as a participant in a DYCD-funded program. In the event of a medical emergency, I hereby give consent for necessary emergency medical treatment for my child to be obtained, with the understanding that I will be notified as soon as possible. I understand that every effort will be made to contact me, or, if I am unavailable, the emergency contact(s) listed, before and after medical care is provided.

☐ **Yes, I give my permission** ☐ **No, I do not give permission**

Parent/Guardian's Signature	Parent/Guardian: Print Name	Date

Consent for Photography/Videotaping and Use of Original Work

As a participant enrolled in a DYCD-funded program, please be aware that from time to time DYCD and the City of New York, its contracted providers, authorized agents, third-party organizations with which it collaborates, or other government, representatives (collectively, "Authorized Parties") may be present during program activities and special events associated with program services, both at the usual program location and at off-site events. In some cases, they may photograph, videotape, interview or otherwise record participants and their families and friends in these programs. The resulting images, videos, and interviews may be used, with or without the participant's name, in printed and electronic media such as brochures, books, print and email newsletters, DVDs and videos, websites, social media and blogs (collectively, "Media").

I hereby authorize and permit the Authorized Parties, without compensation and without further approval, to photograph and/or record my and my child's image, name, likeness, and the sound of my and my child's voice during DYCD-funded program activities and special events, and I hereby consent to the resulting images, videos and interviews being used, without compensation and without further approval by the Authorized Parties solely for non-profit, non-commercial purposes in any and all Media.

☐ Yes ☐ No

If, in the course of participating in DYCD-funded program activities and special events, any original work such as art, music, choreography, poetry, or prose (collectively, "Original Work") is created by me or my child, I hereby consent to such Original Work being used by the Authorized Parties, without compensation and without further approval, solely for non-profit, non-commercial purposes in any and all Media.

☐ Yes ☐ No

If participant is under 18 years old:

Full Name of Participant	Parent/Guardian's Signature	Date

Parent/Guardian Consent to Collect and Share Student Information

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.

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 *(optional):* _____

Additional Parent/Guardian Signature *(optional):* _____

Consent to Make Referrals and Share Information

The New York City Department of Youth and Community (DYCD) invests in programs and services to help our communities and the people who live here. We want to make sure you know about them and make it easy for you to apply.

Why we need your permission

With it, we can:

- send you information about DYCD-funded programs and services you can apply for, and
- share information from your DYCD Participant Application each time you apply.

What we share

We'll only give information to show you qualify or help you enroll in DYCD-funded programs.

Who sees your information and how we protect it

Only authorized DYCD and funded program staff can see it. We don't share it with others except to:

- decide if you're eligible for services,
- enroll you in programs and services, and
- track the results of the services you receive

Please read below, check one of the boxes, and fill in the rest.

I understand why DYCD needs my consent to:

- send me information about programs and services I can apply for,
- refer me to DYCD-funded programs, and/or
- share information from my DYCD Participant Application with the programs I apply for

□ Yes, I give my permission **□ No, I do not give my permission**

_____

Full Name of Participant (please print)

_____

Signature of Participant (or Parent/Guardian for participants under 18 years old)

_____

Date

Hodori SONYC Program at EWSIS
Parent / Guardian Consent

1. I understand and agree that Hodori SONYC program is not responsible for the incidents of my child during the program hours and the dismissal time due to not following Hodori staff's instructions.

2. I understand and agree that my child will participate in field trips provided by the Hodori SONYC program. The Hodori SONYC program is not responsible for the incidents of my child during the field trip due to not following Hodori staff's instructions.

3. I understand and agree that my child will be expected to attend Hodori program every weekday, and **more than three absences will result in automatic disenrollment**. Absences will be excused in case of personal illness, quarantine under the direction of a health officer, personal medical, dental, optometric or chiropractic appointment, and other family emergencies with **a proper notice from parent/guardian**.

4. I understand that this consent will be in effect as of the date of my signing this form and stay in effect as long as my child is enrolled in the Hodori SONYC program.

Student / Applicant Name		Grade	th
Parent / Guardian Name			
Parent / Guardian Signature		Date	

KOREAN AMERICAN FAMILY SERVICE CENTER 뉴욕가정상담소

Hodori SONYC at EWSIS

Emergency Information Sheet

Student / Participant Basic Health Information		
Student / Participant Name:	Date of Birth:	▢ Male ▢ Female
Address:		
Program Acceptance Date:	Date of Discharge:	

Allergies: ▢ **Yes** ▢ **No**
If *Yes*, please list:_____

Children who have special health needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health related service of a type beyond that required by children generally. If your child does have special health care needs, please discuss these with your child-care provider.

Primary Care Provider Name:	Office Phone #:
Dentist Name:	Office Phone #:
Hospital / Medical Facility:	Office Phone #:
Insurance Provider:	Office Phone #:

Emergency Contact Info.

Contact Name	Relationship	Phone Number	Authorized to Pick-Up?
1)			▢ Yes ▢ No
2)			▢ Yes ▢ No

Agreements

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in a neighborhood trip (i.e., library, park and playground) away from the facility under proper supervision. ▢ **Yes** ▢ **No**

In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the medical provider (listed above) necessary for the proper health and well-being of my child. ▢ **Yes** ▢ **No**

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and/or Medical Information) to the provider, as necessary to assist the family in properly caring for my child in case of an emergency. ▢ **Yes** ▢ **No**

I agree to update this information whenever a change occurs and at least once every six months. ▢ **Yes** ▢ **No**

Parent / Guardian Signature:	Date: