RACE:

All information is kept confidential

Check That Apply

O AfterSchool	O Suspension Intervention	O Summer Academy	O Mentoring

INTAKE APPLICATION

"We are the change, Offering our Youth, a Greater Life"

HOUSEHOLD SIZE | INCOME

CATEGORY 1 2 3 4 5 6 7 8

Household Size: _____ **Copy of 3 months paystubs**, please attach.

PERSONAL INFORMATION

Annual Household Income: _____

Child's Full Name:_____ Parent/Legal Guardian: _____
Print Print

Parent/Legal Guardian Household Yearly Income: _____Child on Medicaid: () Yes () No

Child's Date of Birth:_____ Child's Age: ( ) Elem. ( ) Middle Grade: _____ School: _____

School District: _____

T-Shirt size: ☐SM (6-8) M (10-12) ☐ L (14-16)
☐Men SM (XL)

Parent/Legal Guardian Cell: _____ ( ) Okay to leave a message ( ) Not Ok

Parent/Legal Guardian Work #: _____ Parent/GL Email: _____

Mailing Address: _____

REFERRED BY: _____ **CONTACT #** _____ **RELATIONSHIP:** _____

REASON FOR REFERRAL: _____

EILIGIBILTY and REQUIREMENTS

Acceptance into the program is based on the following criteria.

☐1) Child must be rising student in grades 1-8

☐ 2) Child's academic performance must be Below Grade Level or Well Below Grade Level **on Report Card and/or**

☐ 3) Child demonstrated conduct issues throughout the school year and/or

☐ 4) Child experiencing a Transitional Domestic Situation

☐ 5) Low to medium Incomed base (see chart to above)

□ **Report Cards and Testing/Assessment** results are required to be submitted with Interview Intake application. Parents/Guardians are required to attend 65% of the monthly Parent Workshops/PIN (People In Need) of resources & tools. This program is free of cost.

QUESTION TO BE ANSWERED BY THE STUDENT/CHILD

What are some of your hobbies, if any?_____.

What would you like to gain from this program? Help with math/reading.

_____.

Do you desire a Mentor, If so, why? □ Yes x□ No _____,

_____.

HEALTH INFORMATION

Health Information _____/_____ Initials (Parent/LG/Child) Medicaid: _____

Do you have any kind of allergies? Please explain _____,

_____.

Medical concerns ( ) Yes ( ) No. If yes, please list and prescribed medications. _____,

_____.

How often? _____.

Name of Primary Care Physician: _____ Physician #: _____

Address: _____ Medical Insurance: _____

(provide copy of medical card)

Name of Specialist Physician: _____ Specialist Ph. #: _____

Address: _____

Emergency Contact: _____ Work Ph. # _____ Cell #: _____

PLEASE NOTE: All medications must be taken before coming to the program. Greater Life is not responsible or qualified to administer medication to students.

ALTERNATIVE TRANSPORTATION PROVIDER/S:

Name: _____ Contact #: _____

Relationship: _____ **Valid Driver's License #/State: (VDLS)** _____

Additional: _____ Relationship: _____ VDLS: _____

Low (80%)	|	$32,550	$37,200	$41,850	$46,500	$50,250	$53,950	$57,700	$61,400
Very Low (50%)	|	$20,350	$23,250	$26,150	$29,050	$31,400	$33,700	$36,050	$38,350
Extremely Low	|	$12,760	$17,240	$21,720	$26,200	$30,680	$33,700	$36,050	$38,350

Parent/Legal Guardian Signature

Student/Child Signature

Date: _____

Date: _____

Staff Print Name: _____

Date Reviewed and Complete: _____

Date Entered: _____

Enter/File Created/Filed: by Staff: _____