YOUTH MENTORING PROGRAM

First Nations Community HealthSource

Mentee Application

(To Be Completed by the Parent/Guardian)

Feel free to type your answers on the lines provided below or print your application and write your answers with a black or blue pen. Once completed, you may (1) Scan and email your application to YMP Case Managers or (2) Turn in your application at First Nations Community HealthSource – Truman Clinic (625 Truman St. NE Albuquerque, NM 87110). Once submitted, our case managers will contact you shortly.

Personal Information

Youth's Name: _____ Date: _____

Parent/Guardian Name: _____

Relationship to Youth: Mother __ Father __ Other, Specify: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Income (Check range that applies): Email: _____

$0-$100/year ____
$101-$5,000/year ____
$5,001-$10,000/year ____
$10,001-$15,000/year ____
$15,001-$20,000/year ____
$20,001-$35,000/year ____
$35,001-$45,000/year ____
$45,001-$55,000/year ____
$55,001-$75,000/year ____
$75,001-$100,000/year ____
More than $100,001/year ____

Other, (Specify): _____

Date of Birth: _____ Age: _____

Gender: Male: __ Female: __

Ethnicity: Native American: __ Hispanic: __ African American: __

Asian American: __ Other (Specify): _____

Name of School: _____

Grade: K:__ 1st:__ 2nd:__ 3rd:__ 4th:__ 5th:__ 6th:__ 7th:__ 8th:__

9th:__ 10th:__ 11th:__ 12th:__

Emergency Contact Name: _____

Phone Number: _____

Please list all members of your household

Name	Sex	Age	Relationship to Applicant

Application Questions

Please answer all of the following questions as completely as possible. If more space is needed, use an extra sheet of paper or write on the back of this page.

1. Why do you/your child want to participate in a Mentoring program?

2. Briefly describe your expectations for the Youth Mentoring Program:

3. Is your child available to meet with a Mentor eight hours per month and have contact at least once a week for a minimum of one year? Please explain any particular scheduling issues.

4. Is your child willing to attend an initial Mentee training session and two in-service training sessions per year after being matched?

5. Describe your child's school performance including grades, homework, attendance, behaviors, etc.:

6. Does your child have friends? Please describe his/her friendships.

7. Is your child currently having any problems either at home or school?

8. Has your child experienced any traumatic events (i.e., death in the family, abuse, divorce)? If yes, please provide details.

9. Can you provide any additional background information that may be helpful to Youth in matching your son/daughter with an appropriate Mentor?

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Medical History

(To Be Completed by the Parent/Guardian)

Name of Primary Care Physician: _____

Phone Number: _____

Medical Insurance Provider: _____ ___

Policy Number: _____ Phone Number: _____

1. Does your son/daughter have any physical problems or limitations?

2. Is your son/daughter currently receiving treatment for any medical issues?

3. Is he/she currently on any type of medication? Is so, please specify.

4. Does your son/daughter have any known allergies or adverse reactions to medications? If yes, please describe them below:

5. Does your son/daughter have any emotional issues or problems right now?

6. Is your son or daughter currently seeing a counselor or therapist?

   Therapist's Name: _____

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Please read this carefully before signing:

(To Be Completed by the Parent/Guardian)

Youth Mentoring Program appreciates you and your child's interest in becoming a mentee. This application is intended as a means of informing and gaining the consent of the parent/guardian to allow their son/daughter to participate in the Youth Mentoring Program.

After receiving this completed application from you, we will evaluate the information and send you a letter letting you know if your child has been accepted into the Mentoring program. Much of the information you supply in this application packet will be used to match your child with an appropriate Mentor. Therefore, the Mentoring staff may, at times, need to access and share this information with prospective Mentors and other parties when it is in the best interest of the match. However, we do not reveal names until there is an initial interest from the mentee, parent/guardian, and Mentor based first upon anonymous information provided about each other.

Please initial each of the following:

_____ I give my informed consent and permission for my child to participate in the Youth Mentoring Program and its related activities.

_____ I agree to have my child follow all Mentoring program guidelines and understand that any violation on my child's part may result in suspension and/or termination of the Mentoring relationship.

_____ I hereby acknowledge that my child will be transported by his/her Mentor and/or First Nations Community HealthSource staff while participating in the Youth Mentoring Program, and that such transportation is voluntary and at his/her own risk.

_____ I release the Youth Mentoring Program/ First Nations Community HealthSource of all liability of injury, death, or other damages to me, my child, family, estate, heirs, or assigns that may result from his/her participation in the program, including but not limited to transportation, and hold harmless any Youth Mentor, program staff, or other representatives, both collectively and individually, of any injury, physical or emotional, other than where gross negligence has been determined.

_____ (optional) I agree to allow First Nations Community HealthSource to use any photographic image of my child taken while participating in the Mentoring program. These images may be used in promotions or other related marketing materials. First Nations Community HealthSource

I understand I must return all of the following *completed* items along with this application, and that any incomplete information will result in the delay of my application being processed:

- Contact and Information Release Form
- Interest Survey Form

By signing below, I attest to the truthfulness of all information listed on this application and agree to all the above terms and conditions.

Parent/Guardian Signature: _____ Date: _____

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Contact and Information Release

(To Be Completed by the Parent/Guardian)

Youth's Name: _____ Date: _____

School Name: _____

I hereby grant permission for Youth Mentoring Program to make contact with my child and conduct a personal interview for the purposes of applying to be a mentee. Youth Mentoring Program staff may also make contact with my child on school premises for the purposes of screening and interviewing as well as ongoing support of his/her participation in the Mentoring program.

I authorize Youth Mentoring Program staff to obtain any needed information regarding my child from his/her school's staff, including academic and behavioral records and conversations with teachers, counselors, and other administrative staff.

Further, I understand that basic information about my child will be anonymously (without names) shared with a prospective Mentor(s) to aid in determining a suitable match. Once a Mentor/Mentee match is determined, my and my child's identity and other relevant information will be shared with the Mentor to the extent it aids in facilitating a successful match.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Please sign document with an original signature and mail or email this application and items listed above to Youth Mentoring Program Case Managers at First Nations Community HealthSource – Truman Clinic, 625 Truman St. NE, Albuquerque, NM 87110

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Mentee Interest Survey

(To Be Completed By Youth)

Please complete all the following. This survey will help Youth Mentoring Program know more about you and your interests and help us find a good match for you.

What are the most convenient times for you to meet with your Mentor? Please check all that apply.

Weekdays: ___ Lunchtime: ___ After school: ___

Evenings: ___ Weekends: ___ Other: ___

If other, please specify: _____

Do you speak any languages other than English? If so, which languages?

What are some favorite things you like to do with other people?

What are your favorite subjects in school?

If you could learn about a job/career, what would it be?

What are your favorite subjects to read about?

What is one goal you have set for the future?

If you could learn something new, what would it be?

What person do you most admire and why?

Describe your ideal Saturday.

Please check all activities you are interested in:

	Biking		Camping		Science		Cooking		Library
	Hiking		Boating		Music		Sports		Yoga
	Golf		Swimming		Gardening		Parks		Movies
	Fishing		Animals		Eating		Board Games		Shopping

List any other areas of strong interest:

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Parental/Guardian Consent Form for Facebook Access

(To Be Completed by the Parent/Guardian)

We are sending you this parental consent form to request permission for usage of your child's photo/image and/or works to be published on the youth mentoring newsletter, and Facebook page website.

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a web site. Since global access to the Internet does not allow us to control who may access such information, these dangers have always existed; however, we as an organization DO want to celebrate your child and his/her work. The law requires that we ask for your permission to use information about your child.

Pursuant to law, we will not release any personally identifiable information without prior written consent from you as Parent or Guardian. Personal Identifiable information includes student names, photo or image, residential addresses, e-mail addresses, and phone numbers. If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time.

Parents: Please check one of the following choices:

_____ **I/We GRANT** permission for a photo/image that includes this child without any other personal identifiers to be published on the organization website, newsletter, and Facebook page.

_____ **I/We DO NOT GRANT** permission for a photo/image that includes this child without any other personal identifiers to be published on the organization website, newsletter, and Facebook page.

Youth: Please initial each of the following paragraphs:

_____ I agree that while participating in the following sites, I will be respectful to others.

_____ I agree that I will use appropriate language at all times

_____ I will not post any inappropriate pictures

_____ I will respect everyone's opinions and comments

_____ I agree that if at any time I break the rules, First Nations youth mentoring has the right to unfriend/terminate me from their websites, newsletter, and Facebook without any given notice.

By signing this agreement, I acknowledge that I will not be compensated (money, payment, etc.) for use of my photo(s) and First Nations Youth Mentoring Program.

Printed Name of Youth/Child: _____

Printed Name Parent/Guardian: _____

Signature of Parent/Guardian: _____

Relationship to Youth/Child: _____

Parents, we strongly encourage you like our Facebook and join in all the fun! You will get to share experiences with your child(ren) and post memories together.

YOUTH MENTORING PROGRAM

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Medical Release Form for Minor

(To Be Completed by the Parent/Guardian)

Name of Participant: _____ Date of Birth: _____

Name of Parent/Legal Guardian: _____

Address: _____ Phone: _____

City/State/Zip: _____

Permission:

1. I, the parent/legal guardian do hereby verify that the below information is correct and I do hereby grant permission to First Nations Community HealthSource to obtain medical attention for my minor child in case of sickness or injury while participating in your program.
2. I hereby grant permission for an attending physician or hospital to perform whatever care deemed necessary for the welfare of my minor child.
3. I ALSO HEREBY RELEASE, ABSOLVE, INDEMNIFY, HOLD HARMLESS AND FOREVER DISCHARGE FIRST NATIONS COMMUNITY HEALTHSOURCE FROM ANY AND ALL CLAIMS. DEMANDS, ACTIONS, OR CAUSE OF ACTIONS, PAST, PRESENTOR FUTUREARISING OUT OF INURY OR DAMAGE WHILE MY MINOR CHILD IS PARTICPATING IN THE PROGRAM.
4. I assume all risks and hazards incidental to the conduct to the activities and transportation to and from the area. In case of injury to my minor child, I HEREBY WAIVE ALL CLAIMS AGAINST THE ORGANIZAERS, THE SPONSORS, AND OR ANY SUPERVISORS APPOINTED FOR THEM. I LIKEWISE RELEASE FROM RESPONSIBILITY ANY PERSON, INCLUDED AMBULANCE TRANSPORTS, TRANSPORTING MY MINOR CHILD TO AND FROM THE ACTIVITES.
5. I agree to provide medical insurance for my minor child.
6. I understand First Nations Community HealthSource will immediately notify me and/or my designee should a medical emergency arise.

Signature of Participant: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____

Medical and Insurance Information

Family Insurance Company: _____ Policy #: _____

Physician: _____ Phone: _____

Address: _____ City/St./Zip: _____

Immunizations: ___ Tetanus – Date Received: _____

___ Typhoid – Date Received: _____

Emergency Notification

Nearest Relative: _____ Phone: _____

Friend: _____ Phone: _____

YOUTH MENTORING PROGRAM

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Rosenberg Self Esteem Scale-Pre/Post Tests

(To Be Completed by the Parent/Guardian and Youth)

Office Use Only

Pre-Test Data: ___No ___Yes

Post-Test Data: 3 Months ___No ___Yes

6 Months ___No ___Yes

9 Months ___No ___Yes

12 Months ___No ___Yes

Date: _____ Client Name: _____

Birth Date: _____ Age: _____ Grade: _____

Name of School Attending: _____

ROSENBURG SELF-ESTEEM SCALE

Name: _____ Date: _____

Please place a tick in the appropriate box to say whether you strongly agree, agree, disagree, or strongly disagree with the statements below.

	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**
1. As a whole, I am satisfied with myself.				
2. At times I think I am no good at all.				
3. I feel I have a number of good qualities.				
4. I am able to do things as most people.				
5. I feel I do not have much to be proud of.				
6. I certainly feel useless at times.				
7. I feel that I am a person of worth at least on an equal plane with others.				
8. I wish I could have more respect for myself.				
9. All in all I am inclined to feel that I am a failure.				
10. I take a positive attitude towards myself.				

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Mentoring Plan

Youth Mentoring Individualized Plan

(To Be Completed by the Parent/Guardian)

Name of Mentee: _____

Name of Mentor: _____

Date of Plan: _____

Start Date: _____ End Date: _____

GOAL	TIME FRAME FOR COMPLETION	OUTCOME
To improve my grade in _____ (subject) by _____ (percentage) from a letter grade of _____ to a _____.		
To improve my grade in _____ (subject) by _____ (percentage) from a letter grade of _____ to a _____.		
To improve my school attendance from _____ (number of missed days) to _____ (number of missed days).		
To decrease my alcohol/drug use from _____ (weekly use) to _____ (weekly use).		
To decrease my gang involvement from _____ (number of gangs) to _____ (number of gangs).		
To feel better about myself (describe in what ways): a. b. c.		
Other:		
Other:		

YOUTH MENTORING PROGRAM

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Mentee Contract

(To Be Completed by the Parent/Guardian)

Youth's Name: _____ Date: _____

By choosing to participate in the Youth Mentoring Program, I agree to:

- Follow all rules and guidelines as outlined by the Case Managers, Mentee training, program policies, and this contract
- Have a positive attitude and be respectful of my Mentor
- Make a one-year commitment to being matched with my Mentor
- Meet at least four hours per month with my Mentor
- Make at least weekly contact with my Mentor
- Obtain parent/guardian permission for all meeting times at least three days in advance, if possible
- Be on time for scheduled meetings or call my Mentor at least 24 hours beforehand if I am unable to make a meeting
- Discuss monthly meeting times and activities with the Case Managers, and regularly and openly communicate with the Case Managers as requested
- Inform the Case Managers of any difficulties or areas of concern that may arise in the relationship
- Participate in a closure process when that time comes
- Notify the Case Managers if I have any changes in address or phone number
- Attend in service Mentee training sessions twice per year

_____ (please initial) I understand that upon match closure, future contact with my Mentor is beyond the scope of the Youth Mentoring Program and can happen only by the mutual consensus of the Mentor, the mentee, and their parent/guardian.

I agree to follow all the above stipulations of this program as well as any other conditions as instructed by the Case Managers at this time or in the future.

Youth's Signature: _____ Date: _____

Please sign document with an original signature and mail or email this application and items listed above to Youth Mentoring Program Case Managers at First Nations Community HealthSource – Truman Clinic, 625 Truman St. NE, Albuquerque, NM 87110

YOUTH MENTORING PROGRAM

First Nations Community HealthSource

Parent/Guardian Contract

(To Be Completed by the Parent/Guardian)

Parent/Guardian Name: _____ Date: _____

By allowing my son/daughter to participate in the Youth Mentoring Program, I agree to:

- Allow my child to participate in the Youth Mentoring Program and to be matched with a Youth Mentor
- Follow and encourage my child to follow all rules and guidelines as outlined by the Case Managers, Mentee training, program policies, and this contract
- Support my child in this match by allowing him/her to meet with his/her Mentor at least four hours per month and have weekly contact with him/her for one year
- Support my child being on time for scheduled meetings or have him/her call the Mentor at least 24 hours beforehand if unable to make a meeting
- Regularly and openly communicate with the Case Managers as requested
- Inform the Case Managers if I observe any difficulties or have areas of concern that may arise in the match relationship
- Participate in a closure process when that time comes
- Notify the Case Managers if I have any changes in address or phone number
- Provide the Case Managers and the Mentor with any updated health insurance information for my child

_____ (please initial) I understand that upon match closure, future contact between my child and his/her Mentor is beyond the scope of the Youth Mentoring program, and can happen only by the mutual consensus of the Mentor, the mentee, and their parent/guardian.

I agree to follow all the above stipulations of this program as well as any other conditions as instructed by the Case Managers at this time or in the future.

Parent/Guardian Signature: _____ Date: _____

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Department of Finance and Administration
Group Youth Mentoring
2017 Income Verification Form

Youth's Name: _____ Date: _____

Circle the household size and the income level that best fits this youth's household information.

Household Size	Income Level
1	$0 - $12,060
2	$12,061 - $16,240
3	$16,241 - $20,420
4	$20,421 - $24,600
5	$24,601 - $28,780
6	$28,781 - $32,960
7	$32,961 - $37,140
8	$37,141 - $41,320
For households with more than 8 persons add $4,180 for each additional person and complete the following: Household Size: ____ Adjusted Gross Income: _____	

☐ Youth's parent/guardian reports that the household does not have adjusted gross income.

☐ Youth's parent/guardian reports that their household adjusted gross income is above the Federal Poverty Guidelines.

I have provided and verified the information on this document, and I declare under penalty of perjury under the laws of the State of New Mexico that the above facts are true and correct to the best of my knowledge and belief.

_____ _____
Parent/Legal Guardian Signature Date

_____
Printed Name

I have reviewed and verified information provided by the parent/legal guardian of the above listed youth, and I declare under penalty of perjury under the laws of the State of New Mexico that the above facts are true and correct to the best of my knowledge and belief.

_____ _____
Contractor Signature Date

_____ _____
Printed Name Title