



AFC Mentors: Mentee Application

Application Materials (Needed Immediately):

- I. **Qualifications:** Determine if the youth may qualify by answering the nine questions below.
- II. **General Information:** Contact & emergency information.
- III. **Funding Referral:** Information from the Family Networks lead
- IV. **Preferences & Interests:** Information from the youth

Supplemental Materials (Needed before the youth can be matched):

- V. **Self Introduction:** Information from the youth.
- VI. **Additional Information**
- VII. **Health Form, Part A & B**
- VIII. **Parent/Guardian Consent:** Parent/Guardian consents to youth's participation in program
- IX. **Medical Information Release Form**
- X. **Photo/Media Release & Waiver:** Allows AFC Mentoring to use pictures, quotes, etc. for publication purposes (e.g. brochures, flyers, pamphlets, website, PSAs, newsletters, etc.)
- XI. **Driving Permission Form:** Allows AFC Mentoring to transport youth for group events

I. Qualifications

IMPORTANT: If you respond "No" to any of these questions, then please contact AFC Mentoring (617-224-1303) before continuing with this application, as the youth may not qualify for this program.

1. Has the youth had personal experiences with foster care or adoption?
 Yes No
2. Is the youth 7 years or older?
 Yes No
3. Does the youth live in Greater Boston (communities within 10 miles of Boston)?
 Yes No
5. Is it likely the youth will transition outside the Greater Boston area in the next year?
 Yes No
6. Does the youth lack relationships with supportive adults?
 Yes No
7. Does the youth want a mentor?
 Yes No
8. Does the youth have a social worker with the Department of Social Services?
 Yes No
9. Has the Family Networks lead for the youth approved of funding for this applicant?
 Yes No



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II. General Information

Date of this Application: ____ / ____ / ____

MENTEE'S/YOUTH'S CONTACT INFORMATION

Male Female

Mentee's Full Name: _____

Nickname: _____

Home Street Address: _____

DOB: _____

Home City, State: _____ Zip Code: _____

Home Phone: _____

Is the youth:

In Foster Care Adopted Pre-adoptive Residential Care Kinship Care Group Home

Other (please specify out-of-home care situation) _____

What is the youth's permanency plan? _____

Does the youth have an incarcerated parent? (needed for grant data) Yes No

Can the youth meet with his/her mentor at least 8 hours a month for at least a year? Yes No

Does the youth have an adult who can drive/transport him/her places?

Access to Car: Yes No Access to T: Yes No If so, which line(s): _____

CURRENT CARETAKER'S CONTACT INFORMATION

Please check here if address is same as above

Caretaker Name(s): _____

Street Address: _____

Work Phone: _____

City, State: _____ Zip Code: _____

Home Phone: _____

E-mail: _____

Mobile: _____

Do we have permission to seek KidsNet funding?

Yes No

SOCIAL WORKER'S CONTACT INFORMATION

Social Worker Name: _____

Agency Name: _____

Street Address: _____

Day Phone: _____

City, State: _____ Zip Code: _____

Home Phone: _____

E-mail: _____

Mobile: _____

If you are a DCF social worker, please check your DCF branch location:

Boston Regional Office Hyde Park Dimock Street Harbor (Chelsea)

Cambridge/Somerville Arlington Park Street Malden Other: _____

Legal Guardian *** Please state the name(s) of the Legal Guardian(s) of the above named minor.***

Legal Guardian Name(s): _____



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III. Funding Referral

Please note: This form must be completed prior to moving the application forward.

Family Network Lead Contact Information (REQUIRED INFORMATION)

Family Network Lead's Name: _____

E-mail: _____ Phone: _____

Family Network Supervisor's Name: _____

For the Family Networks Lead to complete:

Name of Youth: _____

Do we have permission to match this youth with an AFC Mentor? Yes No

Does this match qualify for Family Networks funding? Yes No

If you answered "No" to either question, then please explain why: _____

When should AFC match the mentee with his/her mentor?

- Match as soon as possible.
- Wait to match the mentee until funding is available.

Funding will be available: _____

Family Network Lead's Signature: _____ Date: _____

Funding Information:

AFC Mentoring is a specialized support and stabilization program for foster and adopted youth. Our mentor selection, mentor training, match support and mentee support are extensive and designed specifically for foster and adopted youth. Having a consistent positive connection has been shown to be a critical component to youth overcoming the challenges they face in foster care, and our goal is to provide youth with long-term relationships in which they can build trust and self-confidence and become empowered to define and achieve success.

AFC has a contract with Family Networks for a fee of \$507.61 per month. This funding is critical to the sustainability of our organization, and we cannot provide services without payment.

Vendor: "Adoption and Foster Care Mentoring, Inc." (aka "Foster and Adoption Mentoring and Enrichment, Inc.").
Vendor ID: VC0000190986 **Service/Program Category:** Support and Stabilization.



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IV. Preferences & Interests (please have the youth answer)

Your Mentor:

Is there someone already in your life that could become a mentor for you? Yes No

AFC Mentoring would be happy to contact that person and train him/her to be your mentor.

Name: _____ Phone: _____

Please match me as soon as possible. I have no strong preferences. Yes No

NOTE: We honor and respect any preferences the youth has. However, selecting the “**Must have it**” box, usually means it takes additional time to find a mentor that fits this preference.

My mentor should be: Female Male
 No preference Would like it Must have it

My mentor should have a background in out of home care (e.g. foster care, adoption, etc.)
 No preference Would like it Must have it

My mentor should have this ethnicity or race: _____
 No preference Would like it Must have it

My mentor should also be: _____
 No preference Would like it Must have it

Your Interests: What do you like to do in your free time? (Give specifics, if possible.)

Play sports? Which ones?	
Play music? What kinds?	
Listen to music? What kinds?	
Read? What kind of books?	
Draw, paint? What kind of art?	
Play video games? What types?	
Watch sports? Which ones?	
Watch TV or movies?	
Shop? For what?	
Other activities?	

Please check one from each of the following pairs below. Are you:

a) talkative or quiet? b) funny or serious? c) energetic or laid back?



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V. Self Introduction (please have the youth answer)

What do you want to be when you grow up?

Why do you want a mentor?

What should your mentor know about you?

VI. Additional Information

Your School Information:

School Name: _____ School City: _____

Grade Level: _____ Favorite Subject: _____ Least Favorite Subject: _____

Language Abilities (optional):	
<input type="checkbox"/>	English
<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Creole
<input type="checkbox"/>	Portuguese
<input type="checkbox"/>	Spanish
<input type="checkbox"/>	Other

Religious Affiliation (optional):	
<input type="checkbox"/>	Agnostic
<input type="checkbox"/>	Christian
<input type="checkbox"/>	Hindu
<input type="checkbox"/>	Jewish
<input type="checkbox"/>	Muslim
<input type="checkbox"/>	Other

Race/Ethnicity (optional):	
<input type="checkbox"/>	African American
<input type="checkbox"/>	Asian American
<input type="checkbox"/>	Caucasian
<input type="checkbox"/>	Hispanic
<input type="checkbox"/>	Native American
<input type="checkbox"/>	Other



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VII. Health Form, Part A

Full Name of Youth: _____

1) Do you have medical insurance? Yes No

Name of Insurance Company: _____	Policy Number: _____
Name of Policy Holder: _____	

2) What is the name of your hospital or health clinic?

Name of Hospital or Clinic: _____	Name of Doctor: _____
Address: _____	Doctor's Phone Number: _____
Phone: _____	

<i>Emergency Contact Information</i>			
Full Name: _____	Relation: _____		
Street Address: _____	Home Phone: _____		
City, State: _____	Zip Code: _____	Mobile: _____	

In case of an emergency, I authorize the AFC staff to seek any medical assistance that the above named youth may require.

Signature: _____ Date: _____



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VII. Health Form, Part B

Full Name of Youth: _____

1) Does the youth have allergies? No Yes *if so, which?*

2) Is the youth on medication? No Yes *if so, which?*

Medicine #1 name: _____ Reason for use: _____

Medicine #2 name: _____ Reason for use: _____

Medicine #3 name: _____ Reason for use: _____

3) Is the youth being treated for any other condition we should know about?

4) Has the youth been identified as having special needs? Please include all information regarding disabilities, hyperactivity disorders, or other behavioral needs.

5) Is there any activity in which the youth may not participate in?

In case of an emergency, I authorize the AFC staff to seek any medical assistance that the above named youth may require.

Signature: _____ Date: _____



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VIII. Parent/Guardian Consent

RE: _____
Name of Youth/Participant

For parent/ guardian to sign:

I, _____ (*full legal name*), provide permission to AFC Mentoring to contact my child's caseworker, _____ (*name of caseworker*), to ask any questions that are directly relevant to this application for my child to be a mentee through AFC Mentoring. These questions may include questions about my child's behavior, required level of supervision, maturity level, ability to interact with the mentor, and other information the caseworker deems relevant.

Signature: _____ Date: _____



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IX. Medical Information Release Form

RE: _____
Name of Youth/Participant

The Health Insurance Portability and Accountability Act (HIPAA) were created to protect the privacy rights of individuals' personal health information. It affects all those who are in contact with medical records or personal health information. Under this law, staff and volunteer members of AFC Mentoring are restricted from sharing information with others regarding injuries or medical conditions of your child unless a release is signed.

As a condition to eligibility to participate in the mentoring programs at AFC Mentoring, parents are required to complete and sign the following statement of disclosure authorization.

I, _____ am authorizing **FULL** disclosure of my child's personal health information in regards to any medical conditions, problems or allergies he or she may have, or any medications or doctor's care that may be prescribed for him or her during the period of my child's participation in any of AFC Mentoring's mentoring programs and activities, or any injury that my child may sustain while participating in any such program or activity. My child's personal health information may be shared with the following individuals:

- AFC Mentoring staff members,
- AFC Mentoring Mentors,
- any Social Worker to whom my child may be assigned, and
- any medical personnel to whom such child may be brought in the event of an emergency.

I understand that I may at any time revoke this authorization in writing. However, by doing so, I understand that I will forfeit my child's participation in AFC Mentoring's mentoring programs and activities.

I understand that if an unauthorized disclosure has been made, I may file a formal complaint with the United States Department of Health and Human Services.

Signature: _____ Date: _____

Witness: _____ Date: _____



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X. Photo/Media Release & Waiver

I, _____, hereby grant AFC Mentoring and its partners (AmeriCorp and Mass Mentoring Partnership) permission to use the following selected items below to publicize and promote AFC Mentoring (e.g. in newsletters, website, etc.).

Please **check AND initial** next to the following items that you will allow AFC Mentoring to publicize:

1) My name:

a) _____ First and last name

b) _____ First name only

2) My visual image:

a) _____ Any visual image (photographic or video images)

b) _____ Non-identifying visual images only (e.g. silhouettes, hands, feet, back)

3) _____ My statements (e.g. quotes, stories, written and/or spoken)

4) _____ My artwork (e.g. drawings, pictures, photos)

I acknowledge that AFC Mentoring or its assignee has total ownership of the program or article in which my above selected information will be used. I understand that I will not receive compensation for the use of such information used to publicize and promote AFC Mentoring.

My consent to this waiver and release signifies that I completely release, promise and covenant not to sue or assert any claims against AFC Mentoring, its personnel, and/or agents of the program for liability that may arise from AFC Mentoring's use of the above selected items for the purposes stated herein.

By signing below, I am acknowledging that I have read and fully understood this Release and Waiver and that I consent to the use of the above selected information to publicize and promote AFC Mentoring.

Print Full Name

Date

Signature of Participant

Date

TO BE COMPLETED BY PARENT/GUARDIAN IF PARTICIPANT IS A MINOR:

I am the legal guardian of the above-named minor and I agree to the terms of this release and consent to the use such minor's above-selected and initialed information for publicity and promotional purposes.

Print Full Name of Parent/Guardian

Date

Signature of Parent/Guardian

Date



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XI. Driving Permission Form

For AFC mentors, staff, and volunteers to drive _____ (youth).

For parent/ guardian/social worker to sign:

Safety while in a car is very important for both drivers and mentees. A mentee cannot ride in a car with a driver without the mentee or mentee's guardians consent. If an accident occurs while the driver is engaged in an AFC Mentoring event, he/she should immediately seek appropriate medical attention and promptly report the incident to AFC staff.

I understand that I had the right to ask any questions before signing this. I do not hold AFC Mentoring responsible for any accident, harm, injury or death that results from driving with the mentor/staff/volunteer driver.

Parent/Guardian signature

Date