Department of Youth & Community Development

CSBG Application, Ages 14+

Welcome to DYCD! The following form will allow you or your child to apply to a DYCD program. One application will be accepted per person per site. Submission of an application does not guarantee eligibility or 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: *Gender, Race, Ethnicity, Language, Population Type, and Health Insurance Status.* Responses to these questions will not impact your status in receiving benefits or services and will not be shared without applicant's permission outside of DYCD. *Income, Household Information, and Education/Work Status* will only impact eligibility for select programs.

Part I: Applicant Information

For the purposes of this application, *applicant* refers to the person applying to receive services. Please 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 male or female)
☐ Not Sure

Applicant's Gender Identity (Select all that Apply):

☐ Female
☐ Male
☐ Non-Binary (not Female or Male)
☐ Gender Nonconforming
☐ Two Spirit (Native American/First Nations)
☐ Another Gender: _____
☐ Not Sure
☐ Do not understand the question
☐ Decline to Answer

Does the applicant identify as transgender?

☐ Yes
☐ No
☐ Not Sure
☐ Do not understand the question
☐ Decline to Answer

Applicant's Gender Pronoun:

☐ She/Her/Hers
☐ He/Him/His
☐ They/Them/Theirs
☐ Another Pronoun: _____
☐ Decline to Answer

Applicant's Sexual Orientation

☐ Heterosexual (straight)
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Pansexual
☐ Asexual
☐ Queer
☐ Questioning
☐ Not Sure
☐ Another Sexual Orientation: _____
☐ Decline to Answer

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Applicant's Race (Select all that Apply):

☐ American Indian and Alaska 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

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*

Is the applicant any of the following:

An Individual with a Disability?	☐ Yes ☐ No ☐ Decline to answer
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

***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

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

☐ Contact information below is for the applicant ☐ Contact information below is for the parent/guardian

Phone Number #1 ☐ Home ☐ Cell ☐ Work	**Phone Number #2** ☐ Home ☐ Cell ☐ Work
Email Address: ☐ No email address	**Preferred Method of Contact**: ☐ Cell Phone ☐ Home Phone ☐ Email ☐ U.S. Mail

Part III: Emergency Contact Information

Emergency Contact Name:	**Emergency Contact Primary Phone Number:** ☐ Home ☐ Cell ☐ Work
Emergency Contact Email Address: ☐ No email address	**Emergency Contact's Relationship to Applicant:** ☐ Emergency contact is parent/guardian of applicant

Part IV: Applicant's Education/Work Status

Applicant's School Type (Select One):

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

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

Elementary School	☐ Pre-K	☐ K	☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	☐ 5th
Middle School	☐ 6th	☐ 7th	☐ 8th				
High School	☐ 9th	☐ 10th	☐ 11th	☐ 12th	☐ Obtained High School Diploma	☐ Obtained High School Equivalency	
Community College	☐ 1st year	☐ 2nd year	☐ 3rd year	☐ 4th year+	☐ Obtained Associate's Degree		
Vocational/Trade School	☐ Some Vocational or Trade School credits, but no certificate or degree attained						
	☐ Obtained a certificate or degree from a Vocational or Trade school						
4-Year College/University	☐ Freshman	☐ Sophomore	☐ Junior	☐ Senior	☐ Obtained Bachelor's Degree		
Master's Degree:	☐ Some Master's Degree credits, but no degree attained						
	☐ Obtained Master's Degree						
Professional Degree	☐ Some Professional Degree credits (e.g. MD, DDS, DVM, LLB, JD), but no degree attained						
	☐ Obtained Professional Degree (e.g. MD, DDS, DVM, LLB, JD)						
Doctorate Degree:	☐ Some Doctorate degree credits, but no degree attained						
	☐ Obtained Doctorate Degree						
Other	☐ Obtained Foreign Degree		☐ No formal schooling attained				
			☐ Obtained IEP Diploma (For Literacy and Immigration programs)				
			☐ Is student in an IEP program? (For NDA High School and Adolescent Literacy programs)				
			☐ Is your resume on file with the provider? (Not applicable for Literacy/Immigration programs)				

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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 NDA High School and Adolescent Literacy Programs : Student ID/OSIS: _____School Type: ☐ Public ☐ Charter ☐ Private ☐ Other _____

School Name: _____School Address:_____ City:_____ Zip Code:_____

Part V: 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 ☐ Two Adults – No Children ☐ Single Person - No children
☐ Single Parent - Male ☐ Two Parent Household ☐ Multigenerational Household
☐ Non-related adults with children ☐ 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+

Applicant's Household 12-Month Gross Income:

$_____

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

☐ Employment Wages ☐ Affordable Care Act Subsidy ☐ Alimony or other Spousal Support ☐ Child Support ☐ Childcare Voucher ☐ Earned Income Tax Credit (EITC) ☐ Employment Tax Credit

☐ General Assistance ☐ Housing Choice Voucher ☐ HUD-VASH ☐ LIEHEAP ☐ Pension ☐ Permanent Supportive Housing ☐ Private Disability Insurance

☐ Public Housing ☐ Safety Net/Home Relief ☐ Retirement Income from Social Security ☐ Social Security Disability Income (SSDI) ☐ Supplemental Security Income (SSI) ☐ Supplemental Nutrition Assistance Program (SNAP) ☐ Temporary Assistance for Needy Families (TANF)

☐ Unemployment Insurance ☐ VA Non-Service Connected Disability Pension ☐ VA Service-Connected Disability Compensation ☐ WIC ☐ Worker's Compensation ☐ Other:_____ ☐ Decline to Answer

Part VI: Applicant's Health Insurance Status

Does the applicant have health insurance? (Select One):	***If yes,* what kind of health insurance does the applicant have? (Check all that Apply)**			
☐ Yes ☐ No ☐ Decline to Answer	☐ Medicaid ☐ Direct-Purchase	☐ Medicare ☐ Employment-Based	☐ State Children's Health Insurance Program ☐ 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)	***If you would like to be contacted about signing up for public health insurance,* what is your preferred method of contact?** (Select One):
☐ Yes ☐ No ☐ Decline to Answer	☐ Email ☐ Phone ☐ US Mail ☐ Via provider ☐ Decline to Answer

Part VII: Universal Consents and Signatures

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, s 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 mage, 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

I acknowledge that I am 18 years of age or older. ☐ Yes ☐ No

If you are 18 and over:

_____

Full Name of Participant

_____ _____

Signature Date

If you are under 18 years old:

_____

Full Name of Participant

_____ _____

Parent's/Guardian's Signature Date

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Consent for Emergency Medical Treatment

FOR ADULT PARTICIPANTS **(AGE 18 AND OVER)**:

I am 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 to be obtained on my behalf. I further authorize the emergency contact listed below to be contacted.

☐ Yes ☐ No

_____
Full Name of Participant

_____
Participant's Signature

_____
Date

In the event of a medical emergency, I designate the following person as an emergency contact:

_____
Name of Emergency Contact

_____
Phone Number

_____
Relationship to Me

FOR PARTICIPANTS WHO ARE MINORS **(UNDER AGE 18)**:

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 listed below, before and after medical care is provided.

☐ Yes ☐ No

_____
Full Name of Participant

_____
Parent's/Guardian's Signature

_____
Parent's/Guardian's Phone Number

_____
Date

In the event of a medical emergency, where I cannot be reached, I designate the following person as an emergency contact:

_____
Name of Emergency Contact

_____
Phone Number

_____
Relationship to Me

_____
Relationship to Child (if applicable)

Parent/Guardian Consent to Collect and Share Student Information (For Full time and Part time (DOE) Students only)

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, 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 With Other DYCD Programs

The New York City Department of Youth and Community Development (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 and check one of the boxes

I understand why DYCD needs me to 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.

If you are 18 and over:

_____

Full Name of Participant

_____ _____

Signature Date

If you are under 18 years old:

_____

Full Name of Participant

_____ _____

Parent's/Guardian's Signature Date

Part VIII: Additional CSBG Questions

Applicant's Health Information (OPTIONAL)

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.) ☐ Yes ☐ No

If Yes: _____

Does the applicant have asthma? ☐ Yes ☐ No

Does the applicant have special health care needs? ☐ Yes ☐ No

If Yes: _____

Does the applicant take medication for any condition or illness? ☐ Yes ☐ No

If Yes: _____

Are there activities the applicant cannot participate in? ☐ Yes ☐ No

If Yes:

Please provide any additional health information details below or ☐ N/A

Please list any accommodation(s) you are requesting for yourself/the applicant below or ☐ N/A

Applicant's Country of Origin:	**Does the Applicant Receive ACS Preventative Services?** ☐ Yes ☐ No

Do you want to be contacted by someone with information about signing up for free financial education or tax assistance programs? ☐ Yes ☐ No

How would you like to be contacted about this? ☐ Via this Provider ☐ Email ☐ Phone ☐ US Mail

Do you want to be contacted by someone with information about child support and arrears programs, and how to make or receive child support payments? ☐ Yes ☐ No

How would you like to be contacted about this? ☐ Via this Provider ☐ Email ☐ Phone ☐ US Mail

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Part IX: Additional Consents and Signatures

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.

In order to continue to receive the funding that supports this program, all of the information requested must be collected. If you have any questions, please ask the provider's Program Director.

If applicant is 18 and over:

I acknowledge that I am 18 years of age or older and am authorized to give consent.

☐ Yes ☐ No

Full Name of Participant	Participant's Signature	Date

If applicant is under 18 years old:

As parent/guardian, I give permission for my child to register and participate in the program and to complete anonymous surveys seeking participant feedback of the program.

Full Name of Participant

Full Name of Parent/Guardian	Parent/Guardian's Signature	Date

Part X: Household Income Verification Forms

Community Services Block Grant (CSBG) Program Participant Self-Certification Form

This program is funded by the Community Services Block Grant (CSBG), which is provided by the U.S. Department of Health and Human Services, Administration for Children and Families Office of Community Services. *You must complete this form to document your eligibility to participate in this program.*

Directions: Please find the number of persons in your household, and then **check the box** that contains the amount of annual household income. **INCOME** is defined as the total annual income 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 anticipated income expected within the next 12 months.

Please check your Income Range based on your household size (for example if there are 5 people in your household, go to HH of 5; if there are 8 in your household go to HH of 8): NOTE: for each additional family member over 8, add $4,540 per person.

Household	0 – 50%	51 – 75%	76 – 100%	101 – 125%	126% - 200%	201%+
Household of 1:	☐ $0 - $ 6,440	☐ $ 6,441 - $ 9,660	☐ $ 9,661 - $12,880	☐ $12,881 - $16,100	☐ $16,101 - $25,760	☐ $25,761+
Household of 2:	☐ $0 - $ 8,710	☐ $ 8,711 - $13,065	☐ $13,061 - $17,420	☐ $17,421 - $21,775	☐ $21,776 - $34,840	☐ $34,841+
Household of 3:	☐ $0 - $10,980	☐ $10,981 - $16,470	☐ $16,471 - $21,960	☐ $21,961 - $27,450	☐ $27,451 - $43,920	☐ $43,921+
Household of 4:	☐ $0 - $13,250	☐ $13,251 - $19,875	☐ $19,876 - $26,500	☐ $26,501 - $33,125	☐ $33,126 - $53,000	☐ $53,001+
Household of 5:	☐ $0 - $15,520	☐ $15,521 - $23,280	☐ $23,281 - $31,040	☐ $31,041 - $38,800	☐ $38,801 - $62,080	☐ $62,081+
Household of 6:	☐ $0 - $17,790	☐ $17,791 - $26,685	☐ $26,686 - $35,580	☐ $35,581 - $44,475	☐ $44,476 - $71,160	☐ $71,161+
Household of 7:	☐ $0 - $20,060	☐ $20,061 - $30,090	☐ $30,091 - $40,120	☐ $40,121 - $50,150	☐ $50,151 - $80,240	☐ $80,241+
Household of 8:	☐ $0 - $22,330	☐ $22,331 - $33,495	☐ $33,496 - $44,660	☐ $44,661 - $55,825	☐ $55,826 - $89,320	☐ $89,321+

I attest that the income information above is true. I understand that falsification of my income is grounds for termination from CSBG program services. I understand that I may be asked to provide income documentation to verify my income. Should my income status change, I hereby agree to promptly notify the program of this change and to submit a revised self-certification form.

Applicant's Name: _____

Applicant Signature:_____**Date:** _____

Parent/guardian:_____**Date:**_____(Signature required if applicant is under the age of 18)

Organization: _____

Intake Specialist/Staff_____**Date:** _____

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