AmeriCorps

YOUTHBUILD

QUAD YOUTHBUILD

45300 N. Baptist Rd.
Hammond, LA 70401
225.567.2350
www.quadyouth.org

2026 ENROLLMENT PACKET

FOR OFFICE USE ONLY

Date Turned in: _____

Applicant Name: _____

Testing Appointment #1: _____

Testing Appointment #2: _____

Interview Appointment: _____

Date Interviewed: _____

MTO Date: _____ Completed MTO? _ Yes _ No

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Welcome Letter from the Director

Dear Potential Quad YouthBuild Participants and Parents,

I would like to welcome you to Quad YouthBuild personally. QYB's aims to provide opportunities for personal transformation through education, career training, community service, and leadership development. By applying to join Quad YouthBuild, you are saying that you want to improve yourself, the lives of those around you, and the community in which you live. You are saying that you are willing to make changes in the way you will live your life. You are choosing to become a leader by participating in something unique in this city. We expect that you will be proud to represent the program long after your training has ended.

Attached you will find information regarding admission and enrollment for all prospective participants. Please carefully read and complete the enrollment forms. If you need assistance with the enrollment process, please contact QYB as we have case managers and staff that will assist you in the process.

All of us here at QYB look forward to the journey that is to come as we work together to ensure a successful year! If you have any questions, feel free to contact us at 225.567.2350 or by email at youthbuild@quadyouth.org.

All the Best,

Crystal Pena
Director

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Application Process

Step 1 – Complete the attached **enrollment packet** and return to:

Quad YouthBuild
45300 N. Baptist Rd.
Hammond, LA 70401

ALL required eligibility documents on the attached checklist must be returned before orientation. Failure to submit the required documents will void the application.

Step 2 – Sign up for the **Remind App** via the attached instructions. All communication from the program regarding testing and enrollment will be sent through the Remind App.

Step 3 – Complete an **educational assessment**. Upon return of the application, the applicant will be scheduled to take an educational assessment for the program to determine HiSET (GED) readiness. The test takes approximately 2 hours, so arrangements will need to be made beforehand. It is very important that the applicant **DOES THEIR BEST** on this test. If an applicant tests too low, they will be referred to Adult Education classes to work on improving basic skills and recommended to apply once those basic skills have seen improvement.

Step 4 – Attend an **interview**. The applicant must attend a brief interview with the QYB staff. The interview will take approximately 30 minutes. If the applicant is a no-show for the interview, the applicant's application will not be accepted. In the case of an emergency, the program must be contacted before the scheduled interview and a new interview time may be given. If the applicant is under 19, the applicant's legal guardian must attend the interview. If the applicant is 19-24 years of age, the applicant is required to have a support person attend the interview with them. This may be a parent, grandparent, aunt, etc… it must be someone that will assist the applicant in completing the program successfully.

Step 5 – Attend **Mental Toughness Orientation** (MTO). This is a 2-week observation period where applicants will be introduced to QYB and the expectations of the program prior to enrollment. Applicants will be observed on their adherence to program policies and procedures. At the completion of MTO, only some applicants will be selected to become QYB participants. Applicants will **not** be paid for MTO.

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REQUIRED DOCUMENTATION FOR ALL PARTICIPANTS:

☐ Birth Certificate

☐ Social Security Card (Must be signed if 18 years old or older)

☐ Louisiana Photo ID (driver or non-driver)

☐ School Records/Drop Slip from the previous school. Do not drop if you are still enrolled.

☐ Proof of income i.e. TANF/food stamp documents, copy of last 6 months' pay stubs, bank statement showing 6 months of direct deposit, parent tax return if under 18, applicant tax return if over 18, documentation from social security medical card, public housing authority paperwork.

☐ Proof of residency if the applicant's physical address does not match the address on the applicant's ID.

☐ Medical Insurance Card

☐ Foster care documentation (if applicable)

☐ Probation/Parole Paperwork (if applicable)

☐ Disability documentation (if applicable)

☐ IEP, if special testing is required (if applicable)

ADDITIONAL REQUIRED DOCUMENTATION FOR ALL PARTICIPANTS UNDER 18:

☐ Parent/Legal Guardian Photo ID, if under 18 (driver or non-driver)

☐ Custody paperwork if the legal guardian is not listed on the birth certificate.

☐ Waiver from the school board

OFFICE USE ONLY:

☐ Verification of Service Registration for males 18 and older

☐ Verification of voter registration, if eligible and over 18

Please note that uniforms are **required** for all participants. QYB will provide participants with 5 QYB shirts, 1 QYB sweatshirt, safety boots, and a clear bag. Participants are **responsible** for purchasing their own khaki pants and belt.

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Membership Application

Date: _____

Name: _____ ☐ Male ☐ Female

Residential Address _____

City: _____ State: _____ Zip: _____

Mailing Address _____

City: _____ State: _____ Zip: _____

Age: _____ D.O.B. _____ Social Security Number: _____/_____/_____

Home Phone: _____ Applicant Cell Phone: _____

Applicant Email Address: _____

Parent Email Address: _____

Applicant Facebook Name(s): _____

U.S. Citizen ☐ Yes ☐ No Registered Selective Service? (Males over 18) ☐ Yes ☐ No ☐ N/A

Are you Hispanic or Latino? ☐ Yes ☐ No ☐ Not Specified

What is your race? (check all that apply)
☐ American Indian or Alaskan ☐ Black or African American ☐ Asian
☐ Hawaiian Native or Pacific Islander ☐ White or Caucasian

Do you have any documented disabilities? ☐ Yes ☐ No ☐ Not Specified
*If yes, please provide IEP or SSDI paperwork

Please mark <u>all</u> fields that apply:
☐ Migrant Youth ☐ Low-income Family ☐ Youth in Foster Care
☐ High School Dropout ☐ Adult Offender ☐ Youth Offender
☐ Child of Incarcerated Parent ☐ Other _____

List your emergency contacts. Numbers <u>MUST BE DIFFERENT</u> from your contact numbers.

Parent / Guardian: _____
Name *Relationship* *Phone*

Emergency Contact 1: _____
Name *Relationship* *Phone*

Emergency Contact 2: _____
Name *Relationship* *Phone*

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Where did you hear about Quad YouthBuild?
☐ Facebook ☐ Instagram ☐ Flyer ☐ School
☐ Former YB member ☐ Court/Probation ☐ Other _____

Are you an English language learner? ☐ Yes ☐ No
Are you registered to vote? ☐ Yes ☐ No ☐ Not Eligible

EDUCATIONAL BACKGROUND

Have you ever been expelled? ☐ Yes ☐ No
If yes, list the school, when, and why. _____

Are you currently enrolled in school? ☐ Yes ☐ No

What is the last school you attended? _____

Last year attended: _____

Last grade you completed (completed meaning you passed:) _____

Why did you not complete school? _____

Were you in special education? ☐ Yes ☐ No If yes, date of last IEP _____

List any special accommodations, i.e., extended time testing, tests read aloud, etc.,
that you received. _____

_____

Have you taken & passed any part of the HiSET? ☐ Yes ☐ No

Mother's highest level of education? ☐ Less than high school ☐ High school diploma or GED ☐ Some college, no degree ☐ Associate's Degree ☐ Bachelor's degree ☐ Master's or doctorate degree

Father's highest level of education? ☐ Less than high school ☐ High school diploma or GED ☐ Some college, no degree ☐ Associate's Degree ☐ Bachelor's degree ☐ Master's or doctorate degree

TRAINING AND WORK HISTORY

Are you currently working? ☐ Yes ☐ No Is your job? ☐ Part-time ☐ Full-time

Current hourly wage? _____ Hours worked per week? _____

Name of Business _____

Have you ever worked in the past? ☐ Yes ☐ No

Where? _____ When? _____

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Construction Experience

Do you understand that we are a construction training program and that you will be required to do construction? ☐ Yes ☐ No

Have you had any construction experience? ☐ Yes ☐ No
If so, please describe. _____

_____

What do you want to do after you finish QYB? (Check one only)

☐ 2-year college
☐ 4-year college
☐ Trade or technical school
☐ Employment
☐ Military, list branch _____
☐ Undecided
☐ Other _____

What are you interested in doing as a career? _____

Do you have any conditions that would make it to where you cannot do construction?
If so, please explain. _____

_____

HEALTH INFORMATION

Do you have any physical, mental, and/or emotional health disorders? ☐ Yes ☐ No
If yes, please describe: _____

Do you take any medications? ☐ Yes ☐ No. If yes, please list _____

When was your last physical exam? _____

When was your last dental exam? _____

Are you receiving mental health or counseling services? ☐ Yes ☐ No

Are you receiving drug/substance abuse counseling? ☐ Yes ☐ No

What type of medical coverage do you have?
☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ No insurance
Please list the provider. _____

Are you supposed to wear glasses or contacts? ☐ Yes ☐ No

Do you have asthma? ☐ Yes ☐ No

Do you vape or smoke? ☐ Yes ☐ No

Do you use drugs recreationally? ☐ Yes ☐ No

Are you supposed to wear glasses or contacts? ☐ Yes ☐ No

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Do you have any allergies we need to be aware of? ☐ Yes ☐ No
If yes, please explain. _____

Do you identify as having a disability? ☐ Yes ☐ No

CRIMINAL RECORD INFORMATION

****Answering yes to any of the questions below WILL NOT disqualify you from QYB. Answer this section HONESTLY. QYB will complete a criminal history check on each participant. Dishonesty may eliminate you from the program.**

Have you been arrested, convicted, or held in police custody? ☐ Yes ☐ No
Are you on probation or parole? ☐ Yes ☐ No
If yes, who is your probation officer? _____

Are you on juvenile or adult probation? _____

When is your probation expected to end? _____

Do you have any pending sentencing, warrants, upcoming court dates? ☐ Yes ☐ No

HOUSING AND INCOME INFORMATION

Household Size: (# of people living in your home) Adults_____ Children ____ Total # _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Household Yearly Income: (CHECK ONE)

_____ $0 - $15,000
_____ $15,001 - $20,000
_____ $20,001 - $25,000
_____ $25,001 - $30,000
_____ $30,001 - $35,000
_____ $35,001 - $40,000
_____ $40,001 - $45,000
_____ More than $45,001

Who do you live with?

☐ One parent
☐ Two Parents
☐ Relative
☐ Friend's House
☐ Adult who is not your legal guardian
☐ Alone, with no adult(s) or with a roommate(s)
☐ Significant Other
☐ Other _____

Is your current living situation stable? ☐ Yes ☐ No
Are you homeless or have been in the past? ☐ Yes ☐ No
Do you have children? ☐ Yes ☐ No
If yes, please how many? _____
If yes, does your child/children live with you? ☐ Yes ☐ No
Do you have any children on the way? ☐ Yes ☐ No
If yes, when is the due date? _____

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Do you identify as LGBTQ? ☐ Yes ☐ No
Are you currently in foster care? ☐ Yes ☐ No
Have you ever been in foster care? ☐ Yes ☐ No

List all household members (including applicant and children). For each individual, list ALL sources of income and amounts for the entire 6 months prior to the application date. You will need to show proof of income.

Full Name	Age	Relationship	Income Source	Gross Monthly Income
		Applicant/Student		

TRANSPORTATION INFORMATION

Do you have transportation to and from QYB? ☐ Yes ☐ No

Who is your daily transportation? _____

Who is your backup transportation? _____

Do you have a valid LA driver's license? ☐ Yes ☐ No
If no, have you completed driver's education? ☐ Yes ☐ No
If no, do you have a TIP card? ☐ Yes ☐ No
Do you have a valid car insurance? ☐ Yes ☐ No
Do you have your own car? ☐ Yes ☐ No

The following people have permission to pick my child up from school: (**if under 19**)
Any changes to this list will need to be made by the legal parent /guardian.

Name _____ Relation _____ Ph _____

Name _____ Relation _____ Ph _____

Name _____ Relation _____ Ph _____

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Must be completed by both applicant and a parent/legal guardian if the applicant is under 19.

Please initial next to each line to indicate your agreement with the following statements. **The parent's initial is on the left and the applicant's on the right.**

_____ _____ 1. In signing this application, I submit that I have answered all the questions accurately. I understand that false information on this form may be grounds for denial of entry to the program or dismissal from the program. I understand that information in this application will be reviewed and verified. In the event, any information in this application is found to be intentionally falsified, by myself, or anyone providing information on my behalf, I understand I may be terminated from the program after acceptance or disqualified before acceptance.

_____ _____ 2. I grant permission for Quad YouthBuild to verify all information contained within this application. Quad YouthBuild will also be authorized to exchange pertinent information during the application process with any school, health provider, social service agency, employer, youth, or criminal justice system that I have come in contact with, in order to evaluate or assist me. All information gathered by Quad YouthBuild on my behalf will remain confidential.

_____ _____ 3. I give permission for QYB to give named applicant basic written and oral exams, physical exams, and/or drug screens as a requirement to be in a workforce training program.

_____ _____ 4. I understand that there are to be no alcohol, drug, vaping, or tobacco products used on the QYB premises, regardless of age.

_____ _____ 5. I understand that QYB does NOT provide transportation to the program, and transportation is the responsibility of the applicant and his/her legal guardian.

_____ _____ 6. I understand that failure to maintain a minimum of 80% attendance will result in a loss of stipend pay and will put the participant on probationary status.

_____ _____ 7. I understand that the program is 7 months long with 12 months of required follow- up services.

_____ _____ 8. I understand the Handbook describes all QYB policies and procedures and we will uphold and honor them.

_____ _____ 9. I understand if the participant arrives more than 15 minutes after the required report time, the participant may be sent home without pay if the van to the training site has already departed.

_____ _____ 10. I understand QYB does not allow cell phones to be used during program time. If one is used, I understand the participant will be fined $50 and received no pay for the day.

_____	_____	_____
Participant Signature	Print Name	Date
_____	_____	_____
Parent/Guardian Signature	Print Name	Date

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PHOTO RELEASE FORM

I give permission for the named participant to appear in any photographs, film, or videotape produced by QYB or their partners, without compensation of any kind. I realize that I can request to see the photographs, films, or videotapes.

QYB shall have the right to exhibit and use the photographs, films, or videotape and retain full sole ownership of all copies. I understand that QYB may use the photographs, films, or videotapes on both social media and/or print materials.

Participant Signature	Print Name	Date
Parent/Guardian Signature	Print Name	Date

TRANSPORTATION PERMISSION SLIP

I hereby give permission for the named participant to be transported by QYB staff in QYB vehicles for the entire period he/she is enrolled in QYB. This may include transportation to and/or from QYB and any off-campus activities that may occur during the program. Examples may include but are not limited to: traveling to and from the occupational training sites, counseling visits, college visits, volunteer activities, field trips.

Participant Signature.	Print Name	Date
Parent/Guardian Signature	Print Name	Date

EMERGENCY PROCEDURE APPROVAL

In the event of an emergency, accident, or illness, when I cannot be contacted, I hereby authorize a QYB program staff to make whatever arrangements are necessary for examination, diagnosis, or emergency medical treatment of the named participant. I understand that I will be responsible for any expenses occurred.

Participant Signature	Print Name	Date
Parent/Guardian Signature	Print Name	Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

This form can be sent with the request for information to verify the participant's agreement to allow his/her school or employment information to be released.

I, _____, hereby authorize and give my consent for Quad YouthBuild and its respective agents and employees to obtain or release information on my behalf.

My consent shall remain in effect until December 31, 2027. This consent is given for information obtainment and release while I am both active in the program and during the required 12-month follow-up period.

I am giving consent to obtain and/ or disclose the following records/information:

- Academic Records. This may include my attendance, grades, and schedules.
- Financial Records. This includes financial aid, and student banking accounts.
- Employment Records including start/end date, wages, hours, attendance records, job title/description, discipline records, the reason for leaving the job
- Counseling
- Substance Abuse Treatment/Urinalysis
- Education/Job Training
- Referrals
- Individual Progress
- Program Termination
- Other _____

I understand that the confidentiality of this information will be maintained in accordance with all applicable laws. I am also aware that no information shall be disclosed to a third party/provider without my informed consent. I acknowledge that this form is valid and expires on the date stated above.

_____	_____	_____
Participant Signature	Print Name	Date
_____	_____	_____
Parent/Guardian Signature	Print Name	Date

Questions – Please contact Quad YouthBuild at (225) 567-2350 or youthbuild@quadyouth.org.

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QYB Attendance Contract

Attendance is important at our school and plays a key role in student success at QYB. To enroll at QYB you must understand our expectations and follow the below terms and conditions. Personalized attendance plans that differ from the below must be approved by our Case Manager and Director and put in writing.

As a participant of QYB, I agree to abide by the following:

- I will strive for an attendance of 90-100% each week
- I will attend the morning meeting at 8:00AMand arrive promptly
- I will strive to book medical or other appointments outside of program hours (8am to 3:00pm)
- I will communicate with the program assistant for all appointments that fall within the school day
- If I am under 18 years of age, I must be signed out by a parent/guardian or someone listed on my sign-out sheets
- Employment opportunities for participants may not interfere with normal program hours
- I understand that continued chronic non-attendance can lead to being dropped from QYB
- I understand that I will not receive a stipend if my attendance falls below 80%
- I will comply with all school rules, dress code, and treat others with respect
- Register and use Remind to receive and send communication with QYB
- Other_____

As a parent/guardian, I agree to abide by the following:

- I will get my child to school every day on time
- Communicate and explain all absences
- Attend all regularly scheduled parent/administrator conferences
- Register and use Remind to receive and send communication with QYB
- Other_____

Participant Signature	Print Name	Date
Parent/Guardian Signature	Print Name	Date

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Statement of Purpose - MUST BE COMPLETED BY APPLICANT

Why have you enrolled at QYB?

What changes will you have to make to complete QYB? Are you ready to make those changes? How do you know?

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EQUAL OPPORTUNITY IS THE LAW

It is against the law for this recipient of Federal financial assistance to discriminate on the following bases: against any individual in the United States, on the basis of race, color, religion, sex (including pregnancy, childbirth, and related medical conditions, sex stereotyping, transgender status, and gender identity), national origin (including limited English proficiency), age, disability, or political affiliation or belief, or, against any beneficiary of, applicant to, or participant in programs financially assisted under Title I of the Workforce Innovation and Opportunity Act, on the basis of the individual's citizenship status or participation in any WIOA Title I–financially assisted program or activity.

The recipient must not discriminate in any of the following areas: deciding who will be admitted, or have access, to any WIOA Title I–financially assisted program or activity; providing opportunities in, or treating any person with regard to, such a program or activity; or making employment decisions in the administration of, or in connection with, such a program or activity.

Recipients of federal financial assistance must take reasonable steps to ensure that communications with individuals with disabilities are as effective as communications with others. This means that, upon request and at no cost to the individual, recipients are required to provide appropriate auxiliary aids and services to qualified individuals with disabilities.

WHAT TO DO IF YOU BELIEVE YOU HAVE EXPERIENCED DISCRIMINATION

If you think that you have been subjected to discrimination under a WIOA Title I–financially assisted program or activity, you may file a complaint within 180 days from the date of the alleged violation with either:

- The Quad Area Community Action Agency, Inc. Equal Opportunity Officer, **Debbie Butler**, P.O. Box 27, Kentwood, LA 70444 or (985) 229-6229

or

- Director, Civil Rights Center (CRC), U.S. Department of Labor
  200 Constitution Avenue NW, Room N-4123, Washington, DC 20210 or electronically as directed on the CRC website at www.dol.gov/crc..

If you file your complaint with the recipient, you must wait either until the recipient issues a written notice of Final Action, or until 90 days have passed (whichever is sooner), before filing with the Civil Rights Center (CRC), U.S. Department of Labor, 200 Constitution Avenue NW, Room N-4123, Washington, DC 20210. If the recipient does not give you a written Notice of Final Action within 90 days of the day on which you filed your complaint, you do not have to wait for the recipient to issue that Notice before filing a complaint with CRC. However, you must file your CRC Complaint within 30 days of the 90-day deadline (in other words, within 120 days after the day on which you filed your complaint with the recipient.) If the recipient does give you a written Notice of Final Action in your complaint, but you are dissatisfied with the decision or resolution, you may file a complaint with CRC. You must file your CRC complaint within 30 days of the date on which you received the Notice of Final Action.

Assurance Statement

As a condition to the award of financial assistance from the Department of Labor, under Title I of WIOA, the grant applicant assures that it will comply fully with the nondiscrimination and equal opportunity provisions of the following laws:

- Title VI of the Civil Rights Act of 1964
- Section 504 of the Rehabilitation Act of 1973
- The Age Discrimination Act of 1975
- Title IX of the Education Amendments of 1972

Quad YouthBuild is an Equal Opportunity Employer/Program. Auxiliary aids and services are available upon request to individuals with disabilities.

Participant Signature.	Print Name	Date
Parent/Guardian Signature	Print Name	Date

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REMIND App

At Quad YouthBuild, we will utilize a communication app called "Remind." This is a free, secure app that can be downloaded to any iPhone or Android device which will allow for our program to communicate easily with you via secured text messaging. Your personal contact information is not visible to the program or anyone associated with the program.

Signing up for messages on Remind is easy.

To receive messages via push notification if you have a smart phone-

Step 1: Download the Remind app on your Android or iOS device, or go to **rmd.me/a** to install the app.
Step 2: Once you've downloaded the app, create a parent or student account with your email address. *Please choose the correct role
Step 3: Go to the Classes tab, tap +, and enter our unique class code @qybapp. This class code will change once programming starts. A new code will be provided at that point.

OR

To receive messages via text notification if you do NOT have a smart phone-

Step 1: Text the message @qybapp to the number 81010.

CONSENT FOR BEHAVIORAL HEALTH SERVICES BY
RKM PRIMARY CARE IN THE QUAD AREA CAA, INC. YOUTH BUILD PROGRAM
****STUDENT CANNOT RECEIVE TREATMENT WITHOUT A SIGNED CONSENT****
READ AND SIGN ALL PAGES. PRINT USING BLACK OR BLUE INK, DO NOT USE PENCIL.

Student's Name: Last First Middle Initial				ID# (Office use only.)
Student's Address (include city):				Zip Code:
Student's Date of Birth:	Sex at Birth: ❑ M ❑ F	Age:	School: **YOUTH BUILD PROGRAM**	
	Gender Identity:		Grade: **N/A**	
Student's Social Security Number:	RACE: ☐Asian Indian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese ☐Other Asian ☐Native Hawai'ian ☐Guamanian / Chamorro ☐Samoan ☐Other Pacific Islander ☐American Indian / Alaska Native ☐Black / African American ☐White ☐More than one ☐Choose not to disclose		Ethnicity (select all that apply): ☐ Not Hispanic ☐ Spanish ☐ Mexican ☐ Mexican-American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic ☐ Choose not to disclose	
Preferred Language:	Parent/Guardian Email:		Student's Cell Phone: ( )	
Name of Mother (include maiden name) or Legal Guardian:		Birthdate:	Home Phone: ( )	Cell Phone: ( )
Name of Father or Legal Guardian:		Birthdate:	Home Phone: ( )	Cell Phone: ( )
Head of Household:		Number of People in Home:		Household Income: $ / year
Emergency Contact:		Relationship:		Phone: ( )
Student's Primary Care Physician: Please check if the student does not have a Primary Care Provider: ❑				Phone: ( )
Student's Dentist: Please check if the student does not have a Dentist: ❑				Phone: ( )
Preferred Pharmacy:	Names of siblings enrolled in the same school:			

Please check the type of health insurance your child has: **Please send a copy of insurance card (front and back) with this form.**	❑ Medicaid/Bayou Health Plan #: _____ (check one below) ❑ Healthy Blue ❑ AmeriHealth Caritas LA ❑ Aetna ❑ LA Healthcare Connections ❑ United Healthcare of LA ❑Humana Healthy Horizons ❑ Private Dental Insurance Co. Name_____ Policy #: _____ ❑ Private Medical Insurance Co. Name: _____ Co. Address: _____ Phone #: _____ Policy #: _____ Group#: _____ Effective Date: _____ Name of policy holder: _____ Policy Holder's Date of birth: _____ Policy Holder Social Security _____ Policy holder relationship to student: _____ Does your insurance pay for prescriptions? ☐ No ☐ Yes ❑ No insurance, would you like information on no cost health insurance? ❑ Yes ❑ No

Is your child allergic to any food or medicine? ❒ No ❒ Yes If yes, list: 1. _____ 2. _____ 3. _____ 4. _____	List of current medications student is on with dosage (how much) and how often: Use separate sheet if necessary. 1. _____ 2. _____ 3. _____ 4. _____

Student Name _____ Student Date of Birth: _____

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE LICENSED MENTAL/BEHAVORIAL HEALTH PROFESSIONAL TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

♦risk assessment, diagnostic, and other preventative mental health screenings ♦behavioral/mental health counseling services (including health education & prevention programs) which includes individual, family and group therapy as deemed appropriate and suitable for care ♦referral and follow-up for behavioral health emergencies ♦referral to specialty care ♦case management ♦telehealth services ♦Medicaid enrollment assistance

Is your child currently being treated for behavioral health issues? ___ Yes ___ No. If so, please indicate the provider: _____.

Please list any medical and/or mental health diagnosis that your child may have. Also, please note any specific concerns you have about your child's social/emotional/behavioral well-being in the home and/or school environment. _____
_____
_____

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS.

I, as parent/guardian, understand that RKM Primary Care shall bill Medicaid and/or my private health insurance company for any behavioral/mental health services provided. I authorize/assign payments of authorized benefits directly to Primary Care Providers For A Healthy Feliciana, Inc. (PCPFHF).

We also understand that the RKM Behavioral Health program is operated by Primary Care Providers for a Healthy Feliciana, Inc., and its employees and contractors. Primary Care Providers for a Healthy Feliciana, Inc. is a nonprofit corporation which operates a network of Federally Qualified Health Centers. Primary Care Providers for a Healthy Feliciana, Inc. has partnered through a memorandum of understanding with the Quad Area CAA, Inc. Youth Build Program to provide mental/behavioral health services. Primary Care Providers for a Healthy Feliciana, Inc. and the FQHCs which they operate are governed by an 11-member board which is not under the governance of the Youth Build Program.

I understand that PCPFHF Clinics may provide services via Tele–Health electronic media. I understand that such services will be used only for providing necessary services and that the professionals involved will respect and protect the confidential nature of the sessions. I also understand that if I object to the use of any electronic media for use in treatment, it will in no way jeopardize my relationship with PCPFHF Clinics. Confidentiality/Consent to Release Information: We consent to the exchange of relevant information between school staff and PCPFHF staff as needed for treatment purposes only. We understand that due to the highly confidential nature of services provided by the program, information will only be shared for safety and/or treatment purposes.

I understand that all Primary Care Providers For A Healthy Feliciana, Inc. locations may participate in one or more health information exchanges (HIEs), whereby PCPFHF, Inc. may share health information with my mutual health care providers for treatment, payment, or health care operations purposes. Opt-out information is available at www.rkmcare.org.

I have read, understand, and authorize the services to be provided at the Youth Build Program. By signing this legal document, I acknowledge that I am the legal parent/guardian who is authorized to sign treatment/legal documents.

_____ _____
Signature of Student **Date**

<u>If under age of 18, a parent/guardian must sign:</u>

_____ _____
Printed name of Parent / Legal Guardian **Relationship**

_____ _____
Signature of Parent / Legal Guardian **Date**

This consent may be withdrawn or modified at any time with **written permission** of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

Louisiana Law R.S. 40:31.3 states that Health Centers in schools are prohibited from:
1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product.

PRIMARY CARE PROVIDERS FOR A HEALTHY FELICIANA, INC

(ALL CLINIC SITES)

NOTICE OF PRIVACY PRACTICES

PURPOSE: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after September 23, 2013 we must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post this Notice in our office in a clear and prominent location where it is reasonable to expect any patient seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

I acknowledge receipt of the Notice of Privacy Practices:

Patient Printed Name	**Patient's Date of Birth**
Patient Signature	**DATE**
Parent / Guardian Printed Name	**DATE**
Parent / Guardian Signature	**DATE**

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

APPLICATION FOR SHARE ACCOUNT

La Capitol FEDERAL CREDIT UNION

You must meet the required minimum balance for each savings-type account you open. For more information, visit us online or call our Personal Assistance Line.

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. ***You must attach a clear copy of your CURRENT DRIVER'S LICENSE or a valid state ID when you return this form to La Cap. Don't forget to attach your Direct Deposit or Payroll Deduction Form.***

Our Routing Number: 265473582

➲ (✓) I WOULD LIKE TO OPEN: ❑ REGULAR SAVINGS ❑ SPECIAL SAVINGS ❑ ELITE SAVER ❑ CHRISTMAS CLUB ❑ VACATION CLUB ❑ SHARE CERTIFICATE ❑ OPPORTUNITY CHECKING ❑ IRA ❑ SIMPLE CHECKING ❑ SIMPLE PLUS CHECKING ❑ CHOICE CHECKING ❑ CHOICE PLUS CHECKING ❑ LIQUID ASSETS CHECKING

NAME (FIRST MI LAST SUFFIX)	DATE OF BIRTH (MO., DAY, YR) — —	SOCIAL SECURITY NO. — —
CURRENT HOME ADDRESS (STREET CITY STATE ZIP CODE) *CANNOT BE A POST OFFICE BOX*		HOME PHONE ( )
MAILING ADDRESS (STREET CITY STATE ZIP CODE) *IF DIFFERENT FROM ABOVE ADDRESS*		CELL PHONE ( )
E-MAIL ADDRESS	DRIVER'S LICENSE #	STATE
EMPLOYER	DIVISION	DATE EMPLOYED — —
HAVE YOU EVER BEEN A MEMBER OF LA CAPITOL FEDERAL CREDIT UNION? ❑ YES ❑ NO	PREFERRED METHOD OF CONTACT	OFFICE PHONE ( )
MOTHER'S MAIDEN NAME	GROSS INCOME / FREQUENCY $ /	

➲ IF YOU'RE ELIGIBLE FOR MEMBERSHIP AS A RELATIVE TO A LA CAP MEMBER, COMPLETE THE FOLLOWING ON THAT MEMBER:

LA CAP MEMBER'S NAME YOU'RE RELATED TO	
THIS MEMBER'S EMPLOYER	DIVISION
THIS MEMBER'S SOCIAL SECURITY #	YOUR RELATIONSHIP TO THIS MEMBER

➲ TAXPAYER IDENTIFICATION NUMBER AND BACK-UP WITHHOLDING

Taxpayer Identification/Social Security Number (Required) ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Under the penalties of perjury, I certify that:
1. The number shown on this form is my correct taxpayer identification number, (or I am waiting for a number to be issued to me), **and**
2. I am not subject to back-up withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to back-up withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to back-up withholding **and**
3. I am a U.S. person (including a U.S. resident alien).

The IRS does not require your consent to any provision of this document other than the certifications required to avoid back-up withholding.

➲ JOINT SAVINGS ACCOUNT AGREEMENT *A copy of each Joint Owner's current Driver's License or a valid state ID MUST be provided when you return this form to La Cap.*

JOINT OWNER (1)	SOCIAL SECURITY NO. — —	DATE OF BIRTH (MO., DAY, YR.) — —
CURRENT HOME ADDRESS (STREET CITY STATE ZIP CODE)	DRIVER'S LICENSE #	STATE
EMAIL ADDRESS	HOME PHONE ( )	CELL PHONE ( )
JOINT OWNER (2)	SOCIAL SECURITY NO. — —	DATE OF BIRTH (MO., DAY, YR.) — —
CURRENT HOME ADDRESS (STREET CITY STATE ZIP CODE)	DRIVER'S LICENSE #	STATE
EMAIL ADDRESS	HOME PHONE ( )	CELL PHONE ( )

Regular, Special, and Share Certificate Accounts
I would like for my ❑ **Regular** ❑ **Special** ❑ **Elite Saver** ❑ **Christmas** ❑ **Share Certificate account(s)** ❑ **Checking** with La Capitol Federal Credit Union to have a joint owner and understand that the La Capitol Federal Credit Union is hereby authorized to recognize any of the signatures subscribed hereto in the payment of funds or the transaction of any business for this account. The joint owners of this account hereby agree with each other and with said Credit Union that all sums now, heretofore or hereafter paid in on shares by any or all of said joint owners with all accumulation thereon, are and shall be owned by them jointly, and be subject to the withdrawal or receipt of any of them, and payment to any of them or the survivor or survivors shall be valid and discharge said Credit Union from any liability for such payment. Any or all of said joint owners may pledge all or any part of the shares in this account as collateral security to a loan or loans. The right or authority of the Credit Union under this agreement shall not be changed or terminated by said owners, or any of them except by written notice to said Credit Union which shall not affect transactions theretofore made:

➲ SIGNATURE

I hereby make application for membership in the La Capitol Federal Credit Union and agree to conform to its bylaws and amendments thereof and subscribe for at least one share. This account is non-transferable. By signing below, I authorize La Capitol FCU to pull my credit report for the verification of the information on this request and offer other products.

SIGNATURE OF MEMBER **X**		DATE
SIGNATURE OF JOINT OWNER (1) **X**	DATE	❑ JOINT CARD
SIGNATURE OF JOINT OWNER (2) **X**	DATE	❑ JOINT CARD

LA CAP USE ONLY: Member # _____ Eligibility # _____ Branch Code _____ Suffix _____

Membership Officer _____ Date _____ Verified by _____ Suffix _____

New Member Packet: ❑ Electronic ❑ In Person ❑ Mailed Credit Score _____ Suffix

CHECKING ACCOUNT AGREEMENT

La Capitol FEDERAL CREDIT UNION

P.O. BOX 3398, BATON ROUGE, LA 70821-3398 • www.lacapfcu.org • 800-522-2748 • 225-342-5055

You hereby authorize La Capitol FCU (La Cap) to establish a checking account in your name subject to the following terms and conditions:

1. Payment of Checks and Other Debit Items
La Cap agrees to pay all properly payable items including checks bearing your signature or facsimiles thereof and to pay electronic debits and/or automatic drafts properly authorized by you. You hereby authorize La Cap to charge such payments and any applicable fees against your account.

2. Stale-Dated Checks
La Cap has no obligation to honor a check, other than one which has been certified, which is presented more than six (6) months after its date, but we may charge your account for a payment made thereafter in good faith.

3. Post-Dated Checks
You agree not to date a check later than the day you write it. If you do write a postdated check and it is presented for payment prior to its written date, La Cap will not be responsible for paying it prior to the written date and may charge your account for the amount of the check.

4. Overdrafts
If you write a check or initiate a debit item for more funds than you have in your account, you will be deemed to be overdrawn and we may refuse to honor the check or other debit item and return it as unpaid due to nonsufficient funds (NSF). Honoring such an overdraft on one or more occasions does not obligate La Cap to do so again in the future.

La Cap may close your account if you incur three(3) or more NSF checks or other debit items, or if you repeatedly deposit items returned unpaid, or if you fail to cover a negative balance promptly, or if you use the account improperly or in a manner likely to cause a loss to La Cap.

5. Provisional Credit
All non-cash items credited to your account are provisional and subject to final payment.

6. Stop Payments
La Cap agrees to stop payment on a check or checks, or other debit item, drawn on this account on which a correct and timely stop payment order has been placed. A stop-payment order must be given in the manner required by law and must be received in time to give us a reasonable opportunity to act on it before our stop-payment cutoff time. Our stop-payment cutoff time is one hour after the opening of the next banking day after the banking day on which we receive the item. Additional limitations on our obligation to stop payment are provided by law. A stop-payment order must precisely identify the number, date, and amount of the item, and the payee. We will honor a stop-payment request by the person who signed the particular item, and, by any other person, even though such other person did not sign the item, if such other person has an equal or greater right to withdraw from this account than the person who signed the item in question. An oral stop payment notice expires after 14 calendar days unless confirmed in writing. A written stop payment notice on a paper check expires after 6 (six) months and must be renewed in writing. A written stop payment notice on an electronic item does not have an expiration date and will remain in effect indefinitely. Stops can be removed from the system upon request in writing. A release of stop-payment request may be made only by the person who initiated the stop payment.

7. Periodic Statements
You agree to exercise reasonable care and promptness in reviewing your periodic statement. If you discover any error or irregularity, you agree to notify us promptly after any such discovery. Otherwise, the statement as printed and/or received, will be deemed to be correct. You further agree that La Cap will not be liable for paying such items if you did not exercise reasonable care in examining your periodic statement or you have not reported the error or irregularity to La Cap within thirty (30) days of when the statement is first made available to you.

8. Liability for Negative or Overdrawn Balances
You agree to be liable for any negative balances as well as any costs incurred by La Cap in collecting said negative balance, such as attorneys fees, court costs, etc., to the extent permitted by law.

9. Authority to Correct Direct Deposit Errors
La Cap will make available receipt of direct deposit services for federal recurring payments to this account and/or receipt of other payments/deposits to you which may be made by way of direct deposit. You authorize La Cap to deduct from this account, or any La Cap account(s) of which you may be an owner, the amount of any funds improperly deposited into this account by way of a federal direct deposit program or by way of any other direct deposit program which you may choose to use.

10. Joint Owners
La Cap is hereby authorized to recognize any of the signatures subscribed below in the payment of funds or the transaction of any business for this account. These joint owners hereby agree with each other and with La Cap that all sums deposited to account are and shall be owned by them jointly, with right of survivorship and be subject to the withdrawal or receipt of any of them, and payment to any of them or the survivor or survivors shall be valid and discharge La Cap from any liability for such payment. Any or all of said joint owners may pledge all or any part of the shares in this account as collateral security to a loan or loans. The right or authority of La Cap under this agreement shall not be changed or terminated by said owners, or any of them except by written notice to La Cap which shall not affect transactions theretofore made.

11. Authority to Change Account Type
You agree that if the terms and conditions required on the checking account you have chosen are not met on a regular basis, La Cap reserves the right to change the account type to Simple Checking.

12. Printed Checks
You agree to use only blank checks and other methods approved by La Cap to withdraw funds from your account. Caution: Checks printed by suppliers other than La Cap's authorized check printer may be of inferior quality, with the MICR line causing them to be rejected during processing and thereby incurring a $5.00 charge per item. It is your responsibility to destroy old checks if your account number changes for any reason. You can avoid this charge by destroying all old checks that contain incorrect information. Only checks that contain correct MICR information will post to the account WITHOUT the $5.00 fee getting assessed.

13. Right To Repayment of Indebtedness
You each agree that La Cap may (without prior notice and when permitted by law) charge against and deduct from this account any amount due and payable debt owed to La Cap now or in the future, by any of the undersigned having the right of withdrawal, to the extent of such persons' or legal entity's right to withdraw.

14. Fees & Charges
Please refer to our Common Features for a schedule of fees to determine the fees applicable to your account.

15. Authority To Amend
You authorize La Cap to amend the terms of this agreement, including fee amounts and/or types of fees, from time to time as deemed necessary by La Cap. La Cap will provide reasonable prior notice of any such amendment to the terms of this agreement if the change could adversely affect you, at which time you may choose to close this account.

I, the undersigned, do hereby acknowledge receipt of a copy of this agreement and the disclosure brochure "Important Information About Share Accounts." I, the undersigned, do hereby agree to the terms and conditions contained in this agreement and to the terms and conditions for this account given in the brochure "Important Information About Share Accounts."

Date:_____ Member-Owner: **X**_____
Print Name

Member Number:_____ **X**_____
Signature

Joint-Owner: **X**_____

Joint-Owner: **X**_____

FOR LA CAP USE ONLY: *2-digit account number:*_____

La Capitol FEDERAL CREDIT UNION

Parental Guarantee of a Minor Account

P.O. BOX 3398, BATON ROUGE, LA 70821-3398 • PHONE: 800-522-2748 or 225-342-5055 • FAX: 800-297-2717 or 225-342-9135 • WWW.LACAPFCU.ORG

I, _____, the undersigned, request La Capitol Federal Credit Union to permit _____, a minor and my son/daughter, to establish and maintain an account with La Capitol Federal Credit Union, and in consideration of doing so, the undersigned hereby agrees to hold your institution harmless and indemnified from and against any and all loss, costs, damage, and expense, including court costs and attorney's fees you may sustain by virtue hereof. I also request La Capitol Federal Credit Union to consider actions by _____ to be one and the same as actions taken by myself as it relates to this account and further agree to accept all responsibility for all actions taken or made, with or without my previous consent and/or knowledge by_____ as it relates to any and all account activity including ATM and debit card usage on account number _____.

It is understood, but not by way of limitation, that this indemnity shall cover the deposit of or negotiation of any and all checks or other instruments for the payment of money by my son/daughter, _____.

In the event that you should, in your sole discretion, permit my son/daughter to create an overdraft in this account, I guarantee the repayment thereof, and it is further understood that you are authorized to charge my account in the event any liability should accrue against me by virtue of the undertakings contained in this letter, or otherwise, for the purpose of satisfying such liability.

X _____ _____

Parent or Legal Guardian *(Signature)* Date

X _____ **X** _____

Witness *(Signature)* Witness *(Signature)*

MXH-1019