Thank you for your interest!
Our hope is that this initiative will help bring community support and resources to people who are on their journey out of poverty. As a volunteer working with our youth, you are an integral part of the creation of the Thriving Connections community.

Youth Community volunteers provide their energy and resources to contribute to leading and implementing the Thriving Connections Initiative while increasing their own awareness and urgency regarding poverty by actively building relationships across race and class lines, and modeling the way.

For more information contact:

**Linda Patton**  
Thriving Connections Coordinator - helps to manage Thriving Connections as a whole  
lindap@insccap.org  
(812) 339-3447 ext. 520

**Katie Thompson**  
Thriving Connections Coach-helps manage Thriving Connections leader and ally relationships

**Emmanuel Scaife**  
Thriving Connections ACE - contact person for IU Service Learning Coordination  
escaife@umail.iu.edu  
(812) 339-3447 ext. 522

All SCCAP services are provided without regard to race, age, color, religion, sex, disability, national origin, ancestry, or status as a veteran.

*The SCCAP Thriving Connections Initiative is part of the South Central Community Action Program [www.insccap.org](http://www.insccap.org)*
SCCAP Thriving Connections Initiative
Youth Community Volunteer Job Description

The Youth Community Volunteer has two primary goals:

- Provide quality, age-appropriate programming for youth of all ages during the Thriving Connections Weekly Community Meetings.
- Increase their own awareness and urgency regarding poverty by actively building relationships across race and class lines, and modeling the way.

Youth Community Volunteer commitment:

- Complete poverty awareness training
- Commit to volunteer on Thursdays from 6:00pm – 8:30pm for a semester, or other time period agreed upon with Thriving Connections staff
- Work together with other volunteers, Youth Community interns, and Thriving Connections staff to implement productive programming for the youth
- Communicate with Thriving Connections staff about availability and scheduling conflicts
SCCAP Thriving Connections Initiative
Youth Community Volunteer Application

Name_________________________________________________ Today’s Date___________

Address___________________________________________ City____________________ State_______

Zip ___________ Phone _______________ E-mail _________________________________

What is the best way to contact you? ________________________________________________

How did you hear about Thriving Connections?
___________________________________________________________

Date of Birth: ___________________________ Marital Status: Single / Married / Widowed / Divorced

Current place of employment __________________________________________________________

Job Title_________________________________________________ Years in Position _____________

Previous Work Experience _____________________________________________________________

________________________________________________________________________________

Highest grade completed (circle) 1-6 7-8 9 10 11 12 Other_____ Major _________________

Do you have a vehicle? _____ Yes _____ No

Why are you interested in participating in Thriving Connections?
What, in your opinion, are the three most common causes of poverty? Please explain:

All participants in the Thriving Connections Initiative are required to do a background check. Background check results will only exclude those with crimes against children.

I am willing to undergo a background check. Please initial _______

All Youth Community volunteers commit to an initial orientation and training with may be held onsite before my first time volunteering at a weekly meeting. After this initial orientation and training, Youth Community volunteers will be expected to attend weekly meetings as agreed upon with the Volunteer Coordinator. We are flexible with your schedule, but require some predictability to make sure we have adequate volunteer coverage.

I am willing to attend an orientation and initial training. Please Initial _______

I am willing to read the Youth Community Volunteer Manual (if applicable), adhere to the policies, and ask questions for clarification. Please Initial _______

I am willing to honor my commitment or let staff know if unforeseen circumstances prevent me from completing my duties. Please Initial _______

Please note: By completing this application you are neither committed to nor ensured participation in the Thriving Connections Initiative. Regardless, we appreciate your interest and the time you took to complete the Volunteer Application.

Signature _________________________________________________________ Date ____________________

SCCAP Thriving Connections Initiative | Youth Community Volunteer Application
All SCCAP services are provided without regard to race, age, color, religion, sex, disability, national origin, ancestry, or status as a veteran.
South Central Community Action Program, Inc.
Volunteer Registration

Name __________________________________________ Birth Date ______________________
Address __________________________________________________________________________
Phone Number ______________________ Email __________________________________________

Volunteer Position (circle all that apply):

- Youth Community Volunteer
- Meal Volunteer
- Transportation Volunteer
- Circle Ally
- Guiding Coalition

I would like to volunteer (circle one):

- Weekly
- Bi-Weekly
- Monthly
- When Needed

I am available (circle one):

- Evenings and Weekends
- Weekdays (list days and times): __________________________________________________

Health concerns/allergies _____________________________________________________________
_________________________________________________________________________________
Primary Physician ____________________________ Phone number ______________________

Family members who might attend Thriving Connections functions with you:

Name __________________________________________ Birth Date ______________________
Health concerns/allergies _____________________________________________________________
_________________________________________________________________________________
Primary Physician ____________________________ Phone number ______________________
Name __________________________________________ Birth Date ______________________
Health concerns/allergies _____________________________________________________________
_________________________________________________________________________________
Primary Physician ____________________________ Phone number ______________________

Emergency Contact Information:

Name________________________________________ Relationship ______________________
Phone ___________________________ Cell Phone __________________
Name________________________________________ Relationship ______________________
Phone ___________________________ Cell Phone __________________
Name________________________________________ Relationship ______________________
Phone ___________________________ Cell Phone __________________
Name________________________________________ Relationship ______________________
Phone ___________________________ Cell Phone __________________
South Central Community Action Program, Inc.
Criminal Record Declaration

South Central Community Action Program (SCCAP) and the Thriving Connections Initiative require a background check of all participants in order to identify and limit potential danger to all participants, especially children. SCCAP will assess the relevancy of any arrests, pending criminal charges or convictions on an individual basis. SCCAP reserves the right to require additional information as necessary to assess the relevancy of any and all information you provide below.

PLEASE NOTE - You need not list the following:

- Any traffic fines of $200.00 or less
- Any offenses, other than offenses related to child abuse and/or child sexual abuse or violent felonies, committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law
- Any convictions the record of which has been expunged under federal or state law
- Any conviction set aside under the Federal Youth Corrections Act or similar state law.

Please list all pending and prior criminal arrests and charges related to child sexual abuse and their disposition. Include dates and jurisdiction. If none, state NONE. Use additional sheets if necessary.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Please list all convictions related to other child abuse and neglect. Include date and jurisdiction. If none, state NONE. Use additional sheets if necessary.

____________________________________________________________
_________________________

Please list all convictions of violent felonies. Include date and jurisdiction. If none, state NONE. Use additional sheets if necessary.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

I understand that providing false or misleading information could result in my not being considered for the Thriving Connections Initiative. I declare, under penalties of perjury, that the above is true and correct to the best of my knowledge.

Applicant Printed Name ________________________________________________________________

Applicant Signature ___________________________________________ Date _________________
South Central Community Action Program, Inc.
Consent for Release of Information for Criminal History & Child Protective Services
State Central Registry Checks

Full Name: _________________________________________________________________

Address: __________________________________________________________________

Date of birth: ___/____/_____ Race/Ethnicity ________ Social Security #: ______ - ______ - ________

Previous Address (es) for past 10 years:

Address: __________________________________________________________________

Address: __________________________________________________________________

Address: __________________________________________________________________

List names of dependent, independent & deceased child (ren): ________________________

Applicant expressly agrees to waive any privileges of confidentiality to permit any and all information to be released to South Central Community Action Program, Inc. (SCCAP) and Child Protective Services. Applicant expressly agrees and understands that any or all information obtained through this signed consent form may be used at the discretion of SCCAP and Child Protective Services in determining the applicant’s suitability for working with children as a Legally Licensed Exempt Provider.

Applicant Signature: _____________________________________ Date: ________________

Witness: ______________________________________ Date: ____________________

For Administrative Use Only:

Type of check: ________Criminal History ________ Child Protective Services

_________ Legally Licensed Exempt Provider ________ Thriving Connections Initiative

Please Check the Appropriate Findings Below:

_________ : Our Agency has no information/record(s) concerning the above named individual.

_________ : Our Agency has the following information/record(s) concerning the above named individual: (Submit documentation or summarize areas you believe should be considered in evaluating the suitability of this individual working for a youth service agency.) Please use the back of the form or contact: ________________________________

Signature: ________________________________ Date: ____________________

Agency: ____________________________________________________________________________

SCCAP Thriving Connections Initiative | SCCAP Background Check Release
SCCAP Thriving Connections Initiative
Photo and Media Release

I hereby grant the South Central Community Action Program, Inc. / SCCAP Thriving Connections Initiative / Thriving Connections Campaign permission to use my likeness in a photograph, video, or other digital reproduction in any and all of its publications, including website entries, without payment or any other consideration. I understand and agree that these materials will be the property of the above organizations.

I hereby irrevocably authorize the South Central Community Action Program, Inc. / SCCAP Thriving Connections Initiative / Thriving Connections Campaign to edit, alter, copy, exhibit or distribute this photo for the purposes of publicizing the above organizations’ programs or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge the South Central Community Action Program, Inc. / SCCAP Thriving Connections Initiative / Thriving Connections Campaign from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contact in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

_____________________________________________________________________________________
PRINTED NAME                                      DATE

_____________________________________________________________________________________
SIGNATURE                                      DATE

If the person signing is under age 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of ________________________________, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

_____________________________________________________________________________________
PRINTED NAME                                      DATE

_____________________________________________________________________________________
SIGNATURE                                      DATE
SCCAP Thriving Connections
Confidentiality Statement

We want you to know that confidentiality is extremely important in the Thriving Connections community. However, there are a few exceptions:

• In the case of potential or suspected abuse or neglect
• In the case of suicide or attempted suicide
• In the case of harm or attempted harm/plan to attempt harm to yourself or someone else

In Indiana everyone is mandated to report suspected child abuse or neglect. For the safety of everyone in the Thriving Connections, a Thriving Connections staff member may need to call child protective services or the police in the above cases. The purpose of mandated reporting is to ensure safety. Please take your concern directly to any of the Thriving Connections staff.

I understand that the relationships within the Thriving Connections community are confidential. Volunteers will not share information unless a report is needed to ensure safety.

Volunteer Signature______________________________ Date____________

Volunteer Print Name_____________________________