****

**ALLY APPLICATION**

**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 to get out of poverty. As an Ally, you will befriend someone who is highly motivated to increase their resources and wants to find and maintain full time employment.

Allies help in the areas of budgeting, educational training, friendship and other supports for a person as they move out of poverty.

A Thriving Connections Ally can be anyone with a stable level of resources who genuinely wants to help and believes everyone has the right to sufficient money, relationships and meaning in their lives to thrive.

At this time, all volunteering is done virtually with the exception of a few outside events that will be socially distanced and some delivery and drop off supports. No volunteer is ever expected to meet in person or is required to attend in person events.

For more information contact:

Linda Patton

Thriving Connections Coordinator

812-339-3447 ext. 520

Cell 812.929.3639

[lindap@insccap.org](mailto:lindap@insccap.org)

Rebecca Mueller

Thriving Connections Lead Coach

812-339-3447 ext. 521

Cell 812.340.6039

[rmueller@insccap.org](mailto:rmueller@insccap.org)

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

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

**SCCAP Thriving Connections**

Ally Job Descriptions

**The Ship Ally has the following primary goals:**

* Build an intentional friendship that is friendly, safe, and supportive with a family in poverty (TC Captain family) and join them in their quest to increase their resources.
* Examine your own hidden rules and how they affect your relationships with people from different economic backgrounds.
* Use the experience of friendship with a family in poverty to advocate within the community for changes in the systems barriers that keep poverty in place

**The Ship Ally commitment:**

* Complete poverty training and Ally trainings as offered
* Spend approximately 10 – 15 hours participating in Thriving Connections activities each month
* Commit to be a Thriving Connections Ally for 18 months or longer
* Attend weekly community meetings regularly (at least once a month)
* Meet monthly with your crew to build relationships, share information, brainstorm action steps, and document your progress
* Offer additional support throughout the month, as needed
* Periodically provide documentation about your progress to help us evaluate the Thriving Connections model
* Be open to the support and new experiences offered by the Thriving Connections community for your own personal growth.

**The Community Ally has the following primary goals:**

* Build an intentional friendship that is friendly, safe, and supportive with all families within TC and support their goals and action steps.
* Be intentional during weekly meetings about helping all community members make connections.
* Examine your own hidden rules and how they affect your relationships with people from different economic backgrounds.
* Use the experience of friendship with a family in poverty to advocate within the community for changes in the systems barriers that keep poverty in place

**The Community Ally commitment:**

* Complete poverty training and Ally trainings as offered
* Spend approximately 2-10 hours participating in Thriving Connections activities each month
* Commit to be a Thriving Connections Ally for an amount of time that you choose
* Attend weekly community meetings regularly (at least once a month)
* Periodically provide documentation about your participation to help us evaluate the Thriving Connections model
* Be open to the support and new experiences offered by the Thriving Connections community for your own personal growth.

**All Allies receive the following supports:**

* Poverty training and Ally Training sessions
* Weekly community meetings in which meals and youth programming are provided
* Collaboration with the others in the community; you are not left in isolation
* On-going support from Thriving Connections Coach and Guiding Coalition

**SCCAP Thriving Connections**

Ally Application

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_

Zip \_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell 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\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a vehicle? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, would you be willing to provide transportation for your TC Leader to events or meetings you

attend together? \_\_\_\_\_ Yes \_\_\_\_\_ No

Why are you interested in participating in Thriving Connections?

Allies are asked to choose a focus area; that is, an area in which they feel they have some strengths to assist a family. Please rank your interests by placing a 1, 2, and 3.

\_\_\_\_\_\_ Education (with TC Captains and/or their children)

\_\_\_\_\_\_ Sustainable Employment (Increasing Income/Decreasing expenses)

\_\_\_\_\_\_ Personal Growth (Socialization and Community Building)

Would you have any reservation or difficulty being matched with a program participant that is, or has:

chemical dependency issues \_\_\_\_\_ yes \_\_\_\_\_ no

mental health issues \_\_\_\_\_ yes \_\_\_\_\_ no

has been in jail or prison \_\_\_\_\_ yes \_\_\_\_\_ no

a person of another race or ethnicity \_\_\_\_\_ yes \_\_\_\_\_ no

a person of another sexual orientation \_\_\_\_\_ yes \_\_\_\_\_ no

a person with domestic abuse issues \_\_\_\_\_ yes \_\_\_\_\_ no

a person of the opposite gender \_\_\_\_\_ yes \_\_\_\_\_ no

*Note: TC Captains must be in recovery from dependencies, or under treatment for mental illness, and must have achieved stability in those areas.*

If you answered “yes” to any of the items in the previous question, please explain:

What, in your opinion, are the three most common causes of poverty? Please explain:

**All participants in Thriving Connections 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\_\_\_\_\_\_\_

**After initial training & orientation, Thriving Connections Allies commit to 6-12 hours a month for 18 months.**

I am willing to attend a 2.5 hour orientation and 6-10 hours of initial training. Please Initial \_\_\_\_\_\_

I am willing to attend a monthly Ally support group meeting. Please Initial \_\_\_\_\_\_

I am willing to participate in one TC community meeting per month. Please Initial \_\_\_\_\_\_

*TC community meetings are weekly on Thursday evenings and include dinner.*

I am willing to meet with my team at least one time per month. Please Initial \_\_\_\_\_\_

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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*

*Thriving Connections Ally Community 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**South Central Community Action Program, Inc.**

Criminal Record Declaration

South Central Community Action Program (SCCAP) and Thriving Connections 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 Thriving Connections. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last Previous

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip County

Date of birth: \_\_\_/\_\_\_\_/\_\_\_\_\_ Race/Ethnicity \_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Previous Address(es) for past 10 years:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip County

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip County

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip County

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 \_\_\_\_\_\_\_\_\_\_\_ Circles® 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**

Photo and Media Release

I hereby grant the **South Central Community Action Program, Inc. / Thriving Connections** 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. / Thriving Connections** 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. / Thriving Connections** 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 you have minor children or 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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and do hereby give my consent without reservation to the foregoing on behalf of this person.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE