



APPLICATION DEADLINE IS JUNE 4, 2016

Return to:  
AKA AKADEMY  
P.O. Box 16784  
St. Petersburg, FL 33733  
[www.zuchochapter.org](http://www.zuchochapter.org)



AKA AKAdemy

AKA AKADEMY: \_\_\_\_\_

**Participant Information (Child)**

Date: \_\_\_\_\_ Participant Name: \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ T-Shirt Size (Youth) \_\_\_\_\_/(Adult) \_\_\_\_\_

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SS# \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Current School Status/Grade for **2016-2017** school year (circle one):

  6     7     8     9  

<b>Race:</b>	_____ Chinese	_____ Native Hawaiian
_____ White	_____ Filipino	_____ Other Asian
_____ American Indian or Alaska Native	_____ Guamanian or Chamorro	_____ Other Pacific Islander
_____ Asian Indian	_____ Japanese	_____ Samoan
_____ Asian Unspecified	_____ Korean	_____ Vietnamese
_____ Black, African American	_____ Multiracial	_____ Some other race

**Ethnicity:**    \_\_\_\_\_ No, Not Spanish/Hispanic/Latino    \_\_\_\_\_ Yes, Other Spanish/Hispanic/Latino  
                   \_\_\_\_\_ Yes, Puerto Rican                                    \_\_\_\_\_ Yes, Mexican, Mexican American, Chicano  
                   \_\_\_\_\_ Yes, Cuban

Student ID # \_\_\_\_\_ School Name: \_\_\_\_\_

Consent \_\_\_\_\_  
(Guardian Initials above)

**Confidentiality Statement:** *The information provided in this form will be used only for the purpose of statistics and reporting to the Juvenile Welfare Board. This information will not be disseminated to the public and will be treated as confidential by AKA AKAdemy staff*

**AKA AKADEMY:** \_\_\_\_\_

**Case/Household Application**

Date: \_\_\_\_\_ Parent/Guardian \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Street Address: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Parent Cell Phone (\_\_\_\_) \_\_\_\_\_

Student Cell Phone (\_\_\_\_) \_\_\_\_\_

PARENT EMAIL ADDRESS: \_\_\_\_\_

STUDENT EMAIL ADDRESS: \_\_\_\_\_

Sisters/Brothers currently enrolled in AKAdemy: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred From: \_\_\_\_\_

<b>Household</b>	\$0-	\$10,000-	\$20,000-	\$30,000 -	\$40,000 -	\$50,000 & up
<b>Income:</b>	\$9999	\$19,999	\$29,999	\$39,999	\$49,999	

(circle one)

**Household Arrangement:**

- \_\_\_ Dual Parent-Married
- \_\_\_ Other-Relative/Kinship Care – Married
- \_\_\_ No Dependents – Married
- \_\_\_ Single Parent – Female Head of Household
- \_\_\_ Dual Parent – Non-Married Female Head of Household
- \_\_\_ Other-Relative/Kinship Care – Female Head of Household
- \_\_\_ No Dependents – Single Female
- \_\_\_ Single Parent - Male Head of Household
- \_\_\_ Dual Parent – Non-Married Male Head of Household
- \_\_\_ Other-Relative/Kinship Care – Male Head of Household
- \_\_\_ No Dependents – Single Male
- \_\_\_ Other – Non Relative
- \_\_\_ No Dependents – Couple, non-married

\_\_\_ Rent Home \_\_\_ Own Home \_\_\_ Other arrangement

\_\_\_ # of Adults In Household

\_\_\_ # of Children In Household

GUARDIAN/ADULT SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

**Intake Date:** \_\_\_\_\_ **AKAdemy Staff Signature:** \_\_\_\_\_

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*Youth Development Foundation of Pinellas County, Inc.*  
*AKA AKAdemy*

**PERMISSION TO PARTICIPATE/RELEASE**

I \_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_, hereby authorize and given consent for my daughter/son to participate in activities related to the AKA AKADEMY PROGRAM for the 2016-2017 program year. Furthermore, I agree to release and hold harmless the Youth Development Foundation of Pinellas County, Inc., Zeta Upsilon Omega Chapter of Alpha Kappa Alpha Sorority Inc., Eta Rho Services Inc., Eta Rho Chapter of Omega Psi Phi Fraternity and individual members, representatives and agents of the aforementioned organizations and any/all agency funders. I, the undersigned have read this release and understand its terms.

\_\_\_\_\_  
Signature of Parent/ Legal Guardian

\_\_\_\_\_  
Date

**MEDICAL RELEASE**

I \_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_, authorize the members of the Youth Development Foundation of Pinellas County AKA AKADEMY staff and members of the Zeta Upsilon Omega Chapter of Alpha Kappa Alpha Sorority to take such actions as necessary for the medical care and treatment of my daughter in the event that I or my emergency contact cannot be reached for authorization. Additionally, I agree to accept responsibility for all costs and expenses incurred for any and all medical services that may be provided.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Emergency Contact/ Relationship

\_\_\_\_\_  
Phone Number/Cell

List health issues/illnesses or allergies which we should be aware of:  
\_\_\_\_\_  
\_\_\_\_\_

**PHOTO/MEDIA/TELEVISION RELEASE**

I \_\_\_\_\_, parent/legal guardian hereby release and consent that photographs that are taken during the course of AKA AKADEMY activities shall become the property of the Youth Development Foundation including without limitation the exclusive right to publish, display, reproduce and distribute the image in all forms or media now known or hereafter developed.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

**PARTICIPANT STATEMENT**

I \_\_\_\_\_, understand that I must abide by all rules of the AKA AKAdemy and all agency funders (YDF, JWB, etc.)

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

**Authorization and Consent for Disclosure,  
Receipt, and Use of Confidential Information  
by the Juvenile Welfare Board of Pinellas County**

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Participant Name: \_\_\_\_\_ Participant Phone: \_\_\_\_\_

Participant DOB: \_\_\_\_\_ Name of Program or Service \_\_\_\_\_

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

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I, \_\_\_\_\_ (*print participant name*) acknowledge that I am a participant of \_\_\_\_\_ (*name of program or service*). I acknowledge that the Juvenile Welfare Board of Pinellas County (“JWB”) provides funds to make the program or service in which I am participating available. I also acknowledge that in order to make sure that all services delivered to participants are of the highest possible quality, JWB may need to review information about me and these services.

By signing this Authorization, I am indicating that I understand and agree that my confidential information may be contained in a JWB data collection system, and that this data collection system is exempt from disclosure under the Florida Public Records Act. This means that by law, JWB cannot release individually identifiable information about me or the services I receive (Fla. Stat. §119.071). I acknowledge that JWB may review all information about me as it specifically relates to any program or service it pays for. I also acknowledge that because JWB provides funds for the program or service in which I am participating, it may review my participant file and all other information pertaining to me held by the agency providing the program or service, regardless of whether that information is entered into a JWB data collection system. I further acknowledge that JWB is simply storing and reviewing records and information as the payor for these services, and that JWB provides no direct services to me, including, but not limited to, coordination of services, recommendation of services, or medical diagnoses. I further acknowledge that JWB is not a covered entity as that term is defined under HIPAA (the Health Insurance Portability and Accountability Act).

I authorize JWB to utilize my confidential information to verify eligibility for funded services or programs, make payment for services rendered to me by funded programs or services, quality control of funded services or programs, evidence-based research of JWB funded services or programs, including, but not limited to, tracking outcomes of funded programs and services, and determination of future services/programs funded by JWB. I understand that the confidentiality of any information disclosed, received or used by JWB related to my Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law unless it is presented in a report that presents information on a group of participants, where no one is identified by name or any other personal characteristic.-

I acknowledge that this Authorization covers all information about me including, but not limited to, personally identifiable information, Protected Health Information, general medical, general counseling, as well as psychiatric/ psychological/ substance abuse information from my medical health record, as allowed by all state, federal and local laws, including, but not limited to the following: Florida Statutes 394.459, 381.004, and 395.3025; Florida Evidence Code 90.503, 90.5035, and 90.5036; HIPAA, and the Code of Federal Regulations (CFR) Title 42. I authorize the release of any information concerning the performance of any tests, results of those tests, counseling and treatment records. I consent to my minor participating in online or paper surveys that



Juvenile Welfare Board

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will be used for program improvements and enhancements. I understand that my records have a privileged and confidential status. I am waiving that status for the purposes contained by this Authorization.

I understand that the confidential information disclosed, received or used by JWB based on this Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law. However, the individually identifiable confidential information received by JWB based on this Authorization may be used by JWB and its agents for research purposes, so long as the research results are reported as a whole in de-identified format, which means that no information that identifies me as an individual is revealed.

I understand that I have the right to withdraw my approval in writing at any time. However, it is possible that JWB may have already relied on this Authorization before it receives notice of my withdrawal and that JWB may have already taken action based on the Authorization. If I do not withdraw my approval, it will automatically end one (1) year from the last day I received services from this program. I understand and agree that if I withdraw my approval that it will not apply to any information already released to and used by JWB as a result of this Authorization.

Specify Above the Date, Event or Condition for Termination of Authorization

By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily, and without coercion, and that I have been given a copy of this authorization, signed by me on the date shown below.

\_\_\_\_\_  
(print participant name)

Signature of Participant or Participant's Authorized Representative (check one):

Effective Date

- Participant
Parent
Guardian
Personal Representative (Legal Documents Required)

Description of authority if signed by participant's authorized representative

Witness Signature

Date



## Juvenile Welfare Board of Pinellas County

14155 58<sup>th</sup> Street North, Suite 100

Clearwater, FL 33760

Phone: 727-453-5600

Fax: 727-453-5610

[www.jwbpinellas.org](http://www.jwbpinellas.org)

### **Written Statement of Purpose(s) for Collection of Social Security Number for Recipients of JWB-funded Programs and Services**

The Juvenile Welfare Board (JWB) invests in partnerships, innovation and advocacy to strengthen Pinellas County children and families. The vision of the Juvenile Welfare Board is that children in Pinellas County will have a future of more successful and satisfying lives because of the efforts of JWB and its partners. JWB was established by Florida statute in 1945 (Special Act 2003-320: F.S. §189.429) and approved overwhelmingly by voters in a referendum in 1946. JWB was created with a mission to provide needed services to children throughout Pinellas County. JWB provides funds to agencies that provide services to children and families in Pinellas County.

The purpose of this document is to provide individuals with written information about how JWB uses the Social Security numbers it collects. JWB is required by Florida's Public Records law [Fla. Stat. §119.071(5)] to provide this information to you.

Florida law allows JWB to collect Social Security numbers in order to carry out its duties and responsibilities (Fla. Stat. §119.071(5) (a) 2a. (II); Special Act 2003-320: F.S. §189.429). Specifically, it is necessary for JWB to collect Social Security numbers to conduct research, fund services, and to ensure that all services delivered to participants are of the highest possible quality.

In addition, collecting Social Security information is necessary to:

- Identify and match individuals and data to research and improve how services are provided to children and families; and
- Receive reimbursement from Medicaid, if applicable, for providing services.

By law, JWB cannot release Social Security numbers (Fla. Stat. §119.071). JWB follows the highest security standards. All reports produced by JWB provide information about services in general. No individual person is ever identified in any way in any report.

\_\_\_\_\_  
Print Participant Name

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Parent/Guardian Name (if participant is under 18)

\_\_\_\_\_  
Parent/Guardian Signature (if participant is under 18)

\_\_\_\_\_  
Date