

Membership Information Form



BOYS & GIRLS CLUBS
OF METRO ATLANTA

For Office Use Only:

Member ID []	Status New [] Renew []	Scholarships Need Hardship [] Staff [] DHR Referral [] Other []	Amount Membership [] Summer [] Partial []
Data Entry Received [] Entered [] Receipt # []	Membership Dates Start [] Termination [] Initial []	Source Amerigroup [] Goizueta [] JC Penney [] CAPS [] FRESH []	Military/BGCA [] Housing Auth. [] Weed & Seed [] Other []

Member Information (Please Print)

First Name: []	Middle Name: []	Last Name: []
Name of Person Member Lives With: []	Home Phone Number: []	Emergency Contact Name: []
Home Address: []		Emergency Phone & Extension: []
City: []	County: []	State: []
Postal Code: []	Email Address: []	

GENDER: <input type="checkbox"/> Female <input type="checkbox"/> Male	BIRTHDATE: [] [] Age: []	ETHNICITY: (CIRCLE ONE) African American Asian American Caucasian Hispanic Multi-Racial Native American Other
School: Name of School: [] []	Grade: []	
Number of Family Members Living in Household []		HOUSEHOLD TOTAL: []
Lives With: (Circle One)		
<input type="checkbox"/> Aunt/Uncle	<input type="checkbox"/> Both Parents	<input type="checkbox"/> Father
<input type="checkbox"/> Mother	<input type="checkbox"/> Grandparent(s)	<input type="checkbox"/> Foster Care/DFACS
Member before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Years: []	Name of Previous Boys & Girls Club: []
		City, State: []

Parent/Guardian

Father's First Name: []	Father's Last Name: []	Father's Work Phone & Ext: []
Father's Employer: []	Father's Occupation: []	Cell Phone: []
Mother's First Name: []	Mother's Last Name: []	Mother's Work Phone & Ext: []
Mother's Employer: []	Mother's Occupation: []	Cell Phone: []
Guardian's First Name: []	Guardian's Last Name: []	Guardian's Work Phone & Ext: []
Guardian's Employer: []	Guardian's Occupation: []	Cell Phone: []

Medical/Emergency

Medical Problems/Allergies: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>		Medications: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	
Physician: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Physician Phone: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Preferred Hospital or Clinic: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Hospital Phone: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Insurance Company: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Insurance Policy Number: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Can Member swim? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Pick up Information

Names of two Persons Authorized to pick up Member.			
1.) First Name: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Last Name: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	2.) First Name: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Last Name: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Persons Not Authorized: First Name <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Last Name <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		

Confidential The following information is necessary for our records and the funding our Organization receives. The answers you provide are completely confidential. Your cooperation in providing this information is both appreciated and necessary.

Medicaid Number: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	CHECK ALL THAT APPLY: Disability(s): <small>Circle 1's Labor Force Status</small>												
ANNUAL HOUSEHOLD INCOME: (CIRCLE ONE)	<input type="checkbox"/> SSDI <input type="checkbox"/> SSI <input type="checkbox"/> TANF <input type="checkbox"/> Day Care Voucher <input type="checkbox"/> Food Stamps <input type="checkbox"/> General Assistance <input type="checkbox"/> School Lunch <input type="checkbox"/> Vet. Compensation												
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">\$10,000 or below</td> <td style="width: 50%; padding: 5px;">\$32,051 – \$35,600</td> </tr> <tr> <td style="padding: 5px;">\$10,001 - \$15,000</td> <td style="padding: 5px;">\$35,601 - \$38,450</td> </tr> <tr> <td style="padding: 5px;">\$15,001 – \$24,900</td> <td style="padding: 5px;">\$38,451 - \$41,300</td> </tr> <tr> <td style="padding: 5px;">\$24,901 - \$28,500</td> <td style="padding: 5px;">\$41,301 - \$44,150</td> </tr> <tr> <td style="padding: 5px;">\$28,501 - \$32,050</td> <td style="padding: 5px;">\$44,151 - \$47,000</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">Over \$47,000</td> </tr> </table>	\$10,000 or below	\$32,051 – \$35,600	\$10,001 - \$15,000	\$35,601 - \$38,450	\$15,001 – \$24,900	\$38,451 - \$41,300	\$24,901 - \$28,500	\$41,301 - \$44,150	\$28,501 - \$32,050	\$44,151 - \$47,000		Over \$47,000	<div style="border: 1px solid black; height: 150px; width: 100%;"></div>
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\$28,501 - \$32,050	\$44,151 - \$47,000												
	Over \$47,000												
Club Defined Confidential Notes:													
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____													

I give the Boys & Girls Club my consent to use photographs, in which my child may appear. I consent to my child participating in outcomes measurements, which include taking surveys and the copying of my child's report card which will be kept confidential.

 Parent or Guardian Signature
 MemberInformation.doc 08/21/01
 Version 6.0 KidTrax©

 Club Member's Signature

Date: Month _____ Day _____ Year _____

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**Georgia Department of Human Services Afterschool Care Program
Income Eligibility Form 2009-2010**

Page 1 of 2

Boys & Girls Club of Metro Atlanta, along with the Georgia Department of Human Services (DHS), are partnering to provide valuable and exciting out-of-school programs for youth in Georgia. The information provided on the following form will help ensure that eligible youth are benefiting from the partnership. We thank you for your cooperation and for allowing us to have an impact on your child's life!

.....

Name of participant: _____

Gender: _____ Male _____ Female Date of Birth (mm/dd/yy): ____/____/____

If the answer to any question below is yes, the family is eligible and the parent or guardian may proceed to the **second page** and sign the Declaratory Statement. If the answer to all questions below is no, please refer to the chart on the **second page** to determine eligibility.

1. Do you receive a TANF check from the Department of Family and Children Services?
 __ yes __ no

2. Do you live in a household that receives Food Stamp benefits? __ yes __ no

3. Do you receive Medicaid or Peachcare for Kids? __ yes __ no

4. Does your child(ren), included in your household, participate in the reduced or free lunch program at school?
 __ yes __ no

Income Eligibility Reporting Form Continued

Page 2 of 2

Family Income Eligibility for the DHS Afterschool Care Program (2009-2010)

Number of Persons in Family Unit	Federal Poverty Level*	DHS Afterschool Services Annual Income Guidelines**	DHS Afterschool Services Monthly Income Guidelines**
1	\$10,830	\$32,490	\$2,707
2	\$14,570	\$43,710	\$3,642
3	\$18,310	\$54,930	\$4,577
4	\$22,050	\$66,150	\$5,512
5	\$25,790	\$77,370	\$6,447
6	\$29,530	\$88,590	\$7,382
7	\$33,270	\$99,810	\$8,317
8	\$37,10	\$111,030	\$9,252
For each additional person, add	\$3,740	\$11,220	\$935

* Income based on the United States Department of Health and Human Services (HHS) 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia. *Source: HHS website: Federal Register, Vol. 74, No. 431, March 6, 2009, pages 9781-9782*

** 300% of the federal poverty level

Family size _____ Gross Yearly Income \$ _____ Gross Monthly Income \$ _____

Declaratory Statement: I (*print name*) _____ certify that all the information given in this form is correct and true to the best of my knowledge. I understand that if I give false information, my child may not be able to participate in the program.

Parent or Guardian Printed Name

Date

Parent or Guardian Signature

Date

Gail B Johnson

Authorized Program Staff Signature

Date

**GEORGIA DEPARTMENT OF HUMAN RESOURCES YOUTH INITIATIVE
AFTERSCHOOL PROGRAM**

Participant Medical Information Form – Page 1

(To be maintained on site for each participant)

STUDENT INFORMATION

Legal Name of Child (*Last, First*): _____ Date of Birth (*MM/DD/YYYY*): _____ Age: _____ Sex (*check one*): Male Female

Street Address: _____ Home Phone No: _____

P.O. Box/Apt #: _____ City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Does the child have health insurance coverage? Name of insurance provider (if applicable):
 Yes No

MEDICAL INFORMATION

Does the child have any allergies? Yes No
 If yes, please list them: _____

Does the child have any other medical conditions (disabilities, infections, viruses, diseases, etc)? Yes No
 If yes, please list them: _____

Is the child currently taking any medications (prescribed and non-prescribed)? Yes No
 If yes, please list them: _____

IN CASE OF EMERGENCY

Contact Name: _____ Relationship to youth: _____ Home Phone Number: _____ Work Phone Number: _____

Alternate Contact Name: _____ Relationship to youth: _____ Home Phone Number: _____ Work Phone Number: _____

PLEASE SIGN PAGE 2 TO VERIFY THE INFORMATION PROVIDED

Medical Information Verification – Page 2

By signing below, I certify the above information is true to the best of my knowledge. I authorize Name of School/Organization Here to contact me if my child is injured and/or harmed in any way. I also authorize Name of School/Organization Here to seek medical attention for my child if he or she is injured and/or harmed and needs immediate medical assistance at a local hospital or emergency care center. I certify that I and/or our family's insurance provider will be responsible for any financial medical costs that may be associated with all medical attention and treatment given to my child. In consideration of their granting my child the opportunity to participate in the Afterschool Program, I hereby release, indemnify and hold harmless the Department of Human Resources and Name of School/Organization Here from any liability, claim or demand resulting from any legal medical attention and assistance that may be needed and provided as a result of an injury or harmful incident to my child.

Legal Name of Parent (print)

Parent Signature

Date