



Hearts **E**verywhere **R**eaching **O**ut for Children, Inc.

*****NOTE: to be eligible, the child must be between the ages 6 and 16 and living with HIV or: 1) have an immediate family member living with HIV (mother, father, brother or sister), 2) have an immediate family member that has died from HIV and/or 3) live with an extended family member (grandmother, grandfather, aunt, uncle or cousin) that is living with HIV. *****

TODAY'S DATE _____

CHILD APPLICATION			
CHILD'S INFORMATION			
First Name	Last Name		Age
Date of Birth (M/D/Y)	Home Address	City	County
Zip	Home Phone	Parent/Guardian's Cell Phone	Parent/Guardian's e-mail address:
Gender at Birth:	Gender Identifies as (if different):		HIV Status:
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____		<input type="checkbox"/> Living with HIV <input type="checkbox"/> Not living with HIV
Is the child aware that he/she is living with HIV or that a member of the household is living with HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, please note why the child is not aware (i.e., too young, concerned they may share this information with others, etc.). _____			
Referral Source (Grady IDP, Friend, Family)			
School Attending:		Grade Level	
Ethnicity: <input type="checkbox"/> Black/African American <input type="checkbox"/> Latino(a)/Latinx/Hispanic/Spanish <input type="checkbox"/> American Indian/Native American/Native Hawaiian/Alaska Native <input type="checkbox"/> Arab American/Middle Eastern <input type="checkbox"/> Asian/Asian American/Pacific Islander <input type="checkbox"/> Caribbean <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Bi/Multi-Racial			
Please provide details if you answer "Yes" to any of the questions in this section.			
Has your child ever been diagnosed with ADD/ADHD?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____			
Has your child ever been diagnosed with a learning disability?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____			
Has your child ever been diagnosed with a developmental disability?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____			
Has your child ever been diagnosed with any mental health issues?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____			
Has your child ever been diagnosed or suffered from any other medical condition?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____			
Has your child ever been a victim of sexual abuse, physical or emotional abuse?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____			

Has your child ever been part of the criminal justice system? Yes No
 If yes, please explain: _____

Who has legal custody of the child? Mother Father Both Parents Aunt/Uncle Grandparent
 Pending court action Other(specify): _____

PARENT/GUARDIAN INFORMATION

First Name		Last Name		Relationship to child:	
Age:	HIV Status: <input type="checkbox"/> Living with HIV <input type="checkbox"/> Not living with HIV			Adoptive Parent: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Highest Level of Education Completed: <input type="checkbox"/> HS <input type="checkbox"/> GED <input type="checkbox"/> Some College <input type="checkbox"/> Associate Degree <input type="checkbox"/> Bachelor Degree <input type="checkbox"/> Master Degree <input type="checkbox"/> Doctorate		
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Disability					
If employed, please provide Company Name:					

ABSENT PARENT INFORMATION

First Name		Last Name		Telephone	
Home Address		City	County		Zip
HIV Status: <input type="checkbox"/> Living with HIV <input type="checkbox"/> Not living with HIV <input type="checkbox"/> HIV status unknown					

HOUSEHOLD INFORMATION

Please list all individuals living in the household:

NAME	RELATIONSHIP TO CHILD	GENDER	AGE	HIV STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HOUSEHOLD ANNUAL INCOME INFORMATION

\$0-10,000
 \$10,001-15,000
 \$15,001-20,000
 \$20,000-25,000
 \$25,001-30,000
 \$30,001-35,000
 \$35,001-40,000
 \$40,001-45,000
 \$50,000+

Source of family income (This information is used for statistical purposes, and will not determine your child's acceptance into the program.)

Employment
 Government support
 Public Assistance
 Unemployment Benefits
 Medicaid
 Social Security
 Veterans Benefits
 Other: _____

IN CASE OF EMERGENCY CONTACT:			
First Name	Last Name	Relationship to Child	
Home Address		City	State Zip
Home Phone Number	Cell Phone Number	Alternate Phone Number	

H.E.R.O. FOR CHILDREN PROGRAMS: (Please check the program(s) you wish your child to participate in)

- Super HEROs (Mentoring Program)
 Bright HEROs (Scholarship Program)
 Camp High Five (Summer Camp)
 Holiday of HEROs (Gift Giving Program)
 Transition to Adulthood (Life Skills Program)

PROGRAM REQUESTS: (Please list the program(s)/activities you would be interested in your child to participating in)

REFERRAL NEEDS:

**H.E.R.O. for Children, Inc. will use collected information for the sole purpose of researching referral agency resources. **

- Food Transitional Housing/Shelter Rent/Utilities Assistance
 Clothing/Furniture Financial/Public Assistance Other: _____

STATEMENT OF UNDERSTANDING

Please initial each statement below and sign below.

- ____ I understand that H.E.R.O. for Children, Inc. programs are free of charge.
____ I understand that H.E.R.O. programs do not meet the state definition of child care, are not licensed by the state of Georgia, and are not subject to the jurisdiction of Bright from the Start.
____ I understand that reviewing this application does not obligate H.E.R.O. to accept my child as a client.
____ I confirm that at least one member of the immediate household and/or a child's immediate family member (i.e. mother, father, brother, sister) is living with HIV/AIDS.
____ I understand, as part of the enrollment process, HERO staff may request additional information about the child prior to making any final decisions related to enrolling your child.
____ I understand all the information given in this application may be verified by H.E.R.O. for Children, Inc.

I attest and certify that all information provided is true and accurate to the best of my knowledge. Furthermore, I understand that any misrepresentation, false statement, or omissions on this application may disqualify my application or result in the immediate dismissal of my child's participation in any H.E.R.O. for Children, Inc. programs.

Parent/Legal Guardian Signature

Date

*****All above information will be kept confidential unless H.E.R.O. is provided with expressed written consent to release any information to requesting party.**

*Mailing Address: 580 W. Crossville Road, Suite 204 ♦ Roswell, GA 30075
Phone : 470-321-3102 ♦ Fax : 470-321-3106 ♦ Email : info@heroforchildren.org*