

**FY 2022-2023**

**Youth Alternatives, Inc.**

Please indicate interests of the youth being enrolled:

Referring Agency/Program:

One Graff Street, Oil City, PA 16301

1250 Elk Street, Franklin, PA 16323

814- 676-5785 Fax: 814- 677-0697

814-346-0188

Email: [kids.rule@yavenangocounty.org](mailto:kids.rule@yavenangocounty.org) Executive Director, Corrina Woods

**REGISTRATION AND RELEASE FORM**

**REGISTRATION**

Name of Youth being enrolled: \_\_\_\_\_

Youth's Birth Date: \_\_\_\_\_ Youth's Social Security Number: \_\_\_\_\_

Has the above youth ever been put in placement through CY5, JPO (please circle if yes), or indicate other? \_\_\_\_\_

Parents/Guardians \_\_\_\_\_  
(First & Last Names of ALL Parents/Guardians in Household)

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

In case of emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

Or contact \_\_\_\_\_ Phone \_\_\_\_\_

Number of YOUTH in Household: \_\_\_\_\_

Number of Adults in Household: \_\_\_\_\_

**LIABILITY RELEASE**

Above youth may be participating in Youth Alternatives programs. I acknowledge the risks and potential risks of some Youth Alternative's programs. However, I feel that the possible benefits to me/my son/my daughter ward are greater than the risks assumed. I hereby am intending to be legally bond for myself, my heirs and assigns, executor or administrators, waive and release forever all claims for damages against Youth Alternatives of Oil City, Inc., its board of directors, instructors, therapists, aides, volunteers and/or employees for any and all injuries and/or losses I, my son/my daughter/my ward may sustain while participating in the Youth Alternative program.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(youth if 18 yrs old, parent, or guardian)

**PHOTO REALEASE**

I hereby consent to and authorize the use and reproduction by Youth Alternatives of Oil City, Inc., of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities, and exhibitions or for any other use for the benefit of the program.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(youth if 18 yrs old, parent or guardian)

# YOUTH ALTERNATIVES, INC.

1 Graff Street, Oil City, PA 16301  
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## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event that emergency aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Youth Alternatives of Oil City, Inc. to:

1. Secure and retain medical treatment and transportation if needed,
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Name of Enrolled Youth: \_\_\_\_\_ Phone: \_\_\_\_\_

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

In the event that I can not be reached, Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
or Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

### CONSENT PLAN

This authorization includes x-ray, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below is unable to be reached.

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Youth if 18 yrs. Old or Parent or Guardian)

### NON-CONSENT PLAN

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event that emergency aid/treatment is required, I wish the following procedures to take place:

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Person Signing Form: \_\_\_\_\_

Phone: \_\_\_\_\_

Additional Health/Medical Comments (if Needed):

The official registration statement and financial information of Youth Alternatives of Oil City, Inc. may be obtained from the Pennsylvania Department of State by calling toll free, within Pennsylvania, 1-800-732-0999. Registration does not imply endorsement.

## MEANS TEST WORKSHEET

### I. IDENTIFYING INFORMATION FOR "SERVICES FOR NON-PLACED CHILDREN"

1. CHILD'S NAME (LAST, FIRST, M.I.)		2. GENDER:  <div style="text-align: right;">                     MALE <input type="checkbox"/>                      FEMALE <input type="checkbox"/> </div>	
3. CHILD'S DATE OF BIRTH	4. CHILD'S MCI NUMBER	5. CHILD'S SSN NUMBER	
6. PERSON WITH WHOM THE CHILD IS LIVING	7. RELATIONSHIP TO CHILD	8. SSN OF PERSON WITH WHOM CHILD IS LIVING	

### II. MEANS TEST FOR "SERVICES FOR NON-PLACED CHILDREN"

1. Is the child/family receiving  TANF (Cash Assistance)  SSI  FOOD STAMPS  
 MEDICAID  NONE If yes, provide Case # \_\_\_\_\_

If services are being received, proceed to question 4. If response is "NONE", proceed to question 2.

2. Is the child a U.S. Citizen or qualified alien?  YES  NO  
 If yes, indicate documentation source:  Birth Certificate  INS  CIS or  Self-Declaration

3. In order to be eligible for "services for non-placed children", a child/family's gross income may not exceed 400 percent of the Federal Poverty Guidelines (FPG) for the family unit size. Using the table below, provide a "YES" or "NO" in Column 4 in the corresponding row for the family size as to whether the child/family's income **is less than** the annual or monthly amount for the family size. (Family unit includes biological, adoptive or step-parents, specified relatives, or non-relative court designated legal custodians and full, half, and/or adopted siblings living in the home under the age of 18 plus the TANF child). This is a self-declared means test. No verification except the response of the family is required.

**Table: 400 Percent of Federal Poverty Guidelines**

Family Unit Size	400% of FPG (gross) (Annually)	400% of FPG (gross) (Monthly)	Yes/No
1	Less than \$51,040	Less than \$4,253	
2	Less than \$68,960	Less than \$5,747	
3	Less than \$86,880	Less than \$7,240	
4	Less than \$104,800	Less than \$8,733	
5	Less than \$122,720	Less than \$10,227	
6	Less than \$140,640	Less than \$11,720	
7	Less than \$158,560	Less than \$13,213	
8	Less than \$176,480	Less than \$14,707	

Note: For family units of more than 8 members, add \$17,920 annually (Column 2) and \$1,493 monthly (Column 3) for each additional member and place the correct figures in the blank row at the bottom of the Table.

4. Is the child under 18 years of age?  YES  NO
5. Is the child living in the home of a parent, other adult specified relative or a court designated legal custodian?  
 YES  NO
6. Is the child/family receiving one of the benefits in question 1 and 4 & 5 are "YES" or answers to 2, 3, 4 and 5 are ALL "YES"?  
 YES  NO

If "YES" to 6, the child is eligible for TANF funding for services for non-placed children.

Means Test Administered for: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

7. Name of staff person administering this means test (Please Print): \_\_\_\_\_