

Young Men's Initiative

Center for Economic Opportunity

Department of Probation

PARTICIPANT APPLICATION

	Next Steps
1.	Social Security Number Last Name 2. Birth Date First Name Middle
3.	Last Name First Name Middle 4.
6.	Street Address (number and street) Apt # Zip Code 7. 8.
9.	Borough (Check one) Bronx Brooklyn Manhattan Queens Staten Island 10. City
11.	Gender (check one) Female Male 12. If Male 18 or above, Selective Service # - 13. Date of Registration
14.	Citizenship Status (Check one) U.S. Citizen Permanent Resident Alien Other Other 15. Your Phone Number
16.	What is your current education/training status? Attending High School/ College Attending GED Attending Training Program Attending Defore graduating Attending Defore graduating Attending School; By Rot attending School; School; Some College Not attending School; School; Some College
17.	Highest Degree Obtained IEP HS Diploma Local HS Diploma Regents HS Diploma GED Associate Degree Degree Other
18.	Last school grade completed 19. Are you currently employed? Yes No
20.	Ethnicity American Asian (Check One) Indian Asian (Non-Hispanic) Black (
21.	Do any of the following apply to you? Court Involved Disabled Foster Care Runaway/ Homeless Parent
22.	Your Email Address Last Name First Name
23.	Emergency Contact Name
24.	Emergency Contact's Relationship to Applicant Relationship to Applicant Relationship to Applicant Relationship to Applicant
26.	Are you currently receiving public assistance? Yes If No, proceed to proceed to question 28. Yes If No, proceed to No question 28. Type of Public for Needy Families (was AFDC) Disability Temporary Assistance for Needy Families (was AFDC) Disability Temporary Assistance for Needy Families (was AFDC) Unemployment Workman's Compensation Other
28.	Is the head of the household you are currently living with receiving public assistance? Yes If No, Type of Public Proceed to 29. Assistance (Check all that apply) Temporary Assistance for Needy Families (was AFDC) Safety Net/ HomeRelief Other
30.	Total family income (gross) for the prior calendar year \$0-\$10,000 \$10,000 \$20,000 \$30,000 \$30,000 \$50
31.	Number of people living in your household (including yourself) Are you covered by Medicaid, Child Health Plus, Family Health Plus, Family Health Plus or private medical insurance? Yes No
33.	If NO, do you want to be contacted with information about public health insurance programs? Yes No
of all	CERTIFICATION STATEMENT I, the undersigned, certify that all information on this form is true and correct. I understand that my statements are subject to verification. I further understand that any statements may subject me to criminal prosecution under both New York State Penal Laws, section 175.35 and Federal Law, 18 U.S.C.A. 1001, and to civil action for return monies received. I agree and accept that I will abide by all applicable rules and regulations of this program.
App	Date Parent/Guardian Signature (if applicant is under 18) Date

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