

# Silver Lining Mentoring: Participant Application

You may use this form to refer a participant for a mentor at SLM through the Community Based Mentoring program.

Please submit referrals to Victoria Murray via:

Email: [victoria@silverliningmentoring.org](mailto:victoria@silverliningmentoring.org)

Fax: 617-451-1025

Mail: 727 Atlantic Ave, 3<sup>rd</sup> Floor; Boston, MA 02111.

If you do not receive confirmation of receipt within one week, please call Victoria at 617-209-5308.

## Part 1: Application Materials

*(Needed Immediately):*

- A. Funding Referral
- B. General Information
- C. Participant Info & Preferences

## Part 2: Supplemental Materials: *(Needed before the participant can start the program):*

- D. Health Form
- E. Medical Information Release Form
- F. Photo/Media Release & Waiver
- G. Permission Form

## Silver Lining Program Opportunities

Silver Lining Mentoring is a specialized support and stabilization program for youth impacted by foster care. Our goal is to empower youth in foster care to flourish through committed mentoring relationships and the development of essential life skills. In addition to Community Based Mentoring, SLM offers several Life Skill Development opportunities for youth who are 16+. **Please check any additional opportunities through SLM which you are interested in for the youth you are referring.** Silver Lining has a Model A-1 contract with Family Networks for a daily fee of \$35.44 (7 days/wk) for a minimum of 3 months.

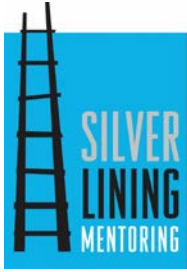
**Silver Lining Community Based Mentoring:** Relationship & Community-Based Services (ages 7 and older)

- Consistent, positive community-based **one-to-one mentoring relationship**
- Bi-monthly **group activities**
- **Coordination of care** with full range of service providers

**Additional Life Skill Supports:** Preparation for Adulthood (ages 16 and older)

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- **Paid internships** offering professional work experience assisting with Silver Lining office projects
- Community-based **life-skills workshops**
- **Self-advocacy/Leadership training** through public speaking opportunities
- Individual **services and support** and connecting participants with needed resources



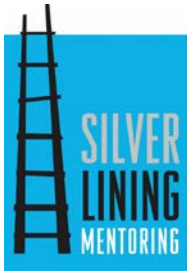
# Silver Lining Mentoring Participant Application

## Qualifications:

Please review the following to see if the youth you have in mind meets the criteria for one, or both, of our services. **IMPORTANT:** If you respond “No” to any of these questions, then please contact Silver Lining Mentoring (617-209-5308) before continuing with this application, as the participant may not qualify for the service(s).

1. Has the participant had personal experiences with foster care?  
 Yes  No
2. Does the participant have a social worker with Department of Children and Families?  
 Yes  No
3. Has the Family Networks lead for the participant approved of funding for this applicant?  
 Yes  No
4. Does the participant want a mentor?  
 Yes  No
5. Is the participant 7 years or older?  
 Yes  No
6. Does the participant live in Greater Boston (communities within 10 miles of Boston)?  
 Yes  No
7. Is it likely the participant will stay within the Greater Boston area in the next 18 months?  
 Yes  No
8. Does the participant lack relationships with supportive adults?  
 Yes  No
9. Can the participant meet with their mentor at least 8 hours a month for at least a year?  
 Yes  No
10. Is the participant interested in being part of SLM's LGBTQ Mentoring Initiative? \*  
 Yes  No

*\*The LGBTQ mentoring initiative matches LGBTQ identified youth with LGBTQ identified mentors.*



# Silver Lining Mentoring Participant Application

## A. Funding Referral - FOR THE FAMILY NETWORKS LEAD TO COMPLETE:

**PLEASE NOTE:** This form must be completed prior to moving the application forward.

Name of Participant: \_\_\_\_\_

Family Network Lead's Name: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Network Director's Name: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

### Funding Information:

Silver Lining has a Model A-1 contract with Family Networks for a fee of \$35.44 per day (7 days/week). The funding commitment for both Community Based and Lifeskills Mentoring is a minimum of at least 3 months, however, **youth are eligible to continue receiving services from Silver Lining Mentoring after funding has been completed.** This funding is critical to the sustainability of our organization, and we cannot provide services without payment.

**Vendor:** "Silver Lining Mentoring"

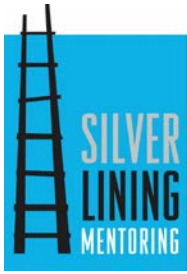
**Vendor ID:** VC0000190986

**Service/Program Category:** Support and Stabilization.

The participant named above is being referred for Community Based Mentoring (minimum of 3 months funding\*)  Yes  No

**Family Network Lead's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*Note:** For Community Based Mentoring, this includes any special outreach we may have to do to recruit and train a specific mentor (see "Mentor Preferences", Section C).



# Silver Lining Mentoring Participant Application

## B. General Information

### PARTICIPANT'S INFORMATION

Date of this Application: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Full Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Male  Female  Transgender: \_\_\_\_\_  Other: \_\_\_\_\_

Current Street Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

DOB: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Best way to reach the mentee:  Text  Call  Email

Where are they currently living?

Foster Home  Adopted Home  Pre-adoptive Home  Residential Care  Kinship

Group Home  Own apartment  Shelter  Pre-Independent Living

Other (please specify) \_\_\_\_\_

**DEMOGRAPHICS:** All questions in this section are optional. Information is being collected for grant purposes and has no bearing on the applicant's program participation.

**When a person's sex and gender do not match, they might think of themselves a transgender. Sex is what a person is born. Gender is how a person feels. Are you transgender?**

- No  
 Yes, and I identify as a boy or man  
 Yes, and I identify as a girl or woman  
 Yes, and I identify some other way  
 I do not know what this question is asking  
 I do not know if I am transgender

**My pronouns are:** \_\_\_\_\_

### **Sexual Orientation:**

- Straight  
 Gay  
 Bisexual  
 Lesbian  
 Questioning  
 Other

### **Race/Ethnicity:**

- Black/African American  
 Asian  
 White  
 Hispanic, Latino or Spanish Origin  
 Native Hawaiian/Pacific Islander  
 Two or more races  
 Other:

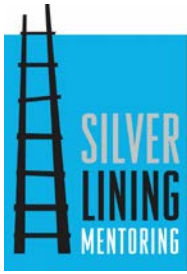
### **Language Abilities:**

- English  
 Chinese  
 Creole  
 Portuguese  
 Spanish  
 Other

### **Disability:**

- Autism  
 Learning Disability  
 Developmental Disability  
 Traumatic Brain Injury  
 Mental Health Disability (ex: depression, anxiety, PTSD)  
 Speech or Language Disability  
 Orthopedic Impairment  
 Other Health Impairment  
 Intellectual Disability  
 Multiple Disabilities

**If participant identifies as LGBTQ based on the questions above, does the participant want to be part of Silver Lining's LGBTQ Mentor Initiative?**  Yes  No



# Silver Lining Mentoring Participant Application

## **CURRENT CARETAKER'S CONTACT INFORMATION**

Caretaker Name(s): \_\_\_\_\_

Check if address is same as above

Current Street Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred mode of contact:  Primary Phone  Secondary Phone  Email

Preferred Days/Times for Contact: \_\_\_\_\_

## **SOCIAL WORKER'S CONTACT INFORMATION**

Social Worker Name: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Supervisors Name: \_\_\_\_\_

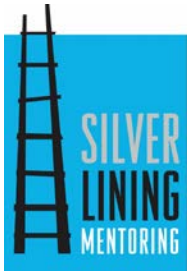
Primary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**LEGAL GUARDIANS NAME:** \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

N/A: Participant is their own legal guardian

## **DATABASE PERMISSION:** *(consent required for all individuals to participate in program)*

To evaluate effectiveness and make continuous program improvements, Silver Lining Mentoring collects demographic and survey information from the participants in our services. Information is entered into a secure database, Salesforce, that can only be accessed by program & evaluation staff at Silver Lining Mentoring. Silver Lining Mentoring will never share a participant's personal information without explicit consent. By submitting this referral, I understand that Silver Lining Mentoring will collect and utilize participant data in the Salesforce database.



# Silver Lining Mentoring Participant Application

## C. Participant Information *Participant to complete this section (if needed, please provide help to participant to complete this section)*

### MENTOR PREFERENCES

Is there someone already in your life that could become a mentor for you?  Yes  No  
*Silver Lining would be happy to contact this person and explore whether they can be your mentor.*

Name: \_\_\_\_\_

Relationship to participant: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred mode of contact:  Primary Phone  Secondary Phone  Email

The below questions help us select which mentor would be best for you.

**1. I have no strong preferences. Please match me as soon as possible.**

Yes  No

**2. My mentor should have this gender identity:**

Female  Male  Other: \_\_\_\_\_  
 No preference  Would like it  Must have it

**3. My mentor should have a background in out of home care (e.g. foster care, adoption, etc.)**

No preference  Would like it  Must have it

**4. My mentor should be this ethnicity or race: \_\_\_\_\_**

No preference  Would like it  Must have it

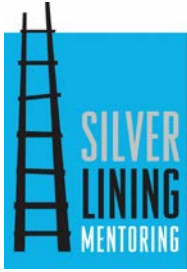
**5. My mentor should be this sexual orientation: \_\_\_\_\_**

No preference  Would like it  Must have it

**6. My mentor should also be: \_\_\_\_\_**

No preference  Would like it  Must have it

**NOTE:** We honor and respect any preferences the participant has. However, selecting the "Must have it" box usually means it takes additional time to find a mentor that fits this preference.



# Silver Lining Mentoring Participant Application

**Participant to complete this section** (if needed, please provide help to participant to complete this section)

**PARTICIPANT INTERESTS:** What do you like to do in your free time? (Give specifics, if possible.)

- Play Sports. Which ones? \_\_\_\_\_
- Play music. What kinds? \_\_\_\_\_
- Listen to music. What kinds? \_\_\_\_\_
- Read. What kinds of books? \_\_\_\_\_
- Draw / Paint/Arts & Crafts. What kind of art? \_\_\_\_\_
- Play video games. What types? \_\_\_\_\_
- Watch TV/Movies. What kind? \_\_\_\_\_
- Shop. For what? \_\_\_\_\_
- Other activities? \_\_\_\_\_

**Please check one from each of the following pairs below. Are you:**

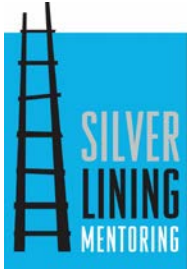
- a)  talkative or  quiet?      b)  funny or  serious?      c)  energetic or  laid back?

## **SELF-INTRODUCTION**

What do you want to be or do when you grow up?

Why do you want a mentor?

What should your mentor know about you?



# Silver Lining Mentoring Participant Application

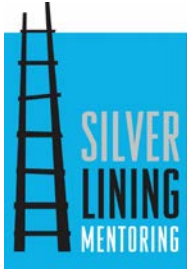
**\*If you haven't yet, please complete part 1 of the application. Referrals cannot be accepted without part 1 completed\*\***

## **Part 2: Supplemental Materials**

*(Needed before the participant can start the program):*

- E. Health Form
- F. Medical Information Release Form
- G. Photo/Media Release & Waiver
- H. Permission Form





# Silver Lining Mentoring Participant Application

## D. Health Form

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

1) Does the participant have allergies?      **No**                       **Yes if so, which?**

\_\_\_\_\_

\_\_\_\_\_

2) Is the participant on medication?             **No**                       **Yes if so, which?**

Medicine #1 name: \_\_\_\_\_ Reason for use: \_\_\_\_\_

Medicine #2 name: \_\_\_\_\_ Reason for use: \_\_\_\_\_

3) Is the participant being treated for any other condition we should know about?

4) Has the participant been identified as having special needs? Please include all information regarding disabilities, hyperactivity disorders, or other behavioral needs.

5) Is there any activity in which the participant may not participate?

6) Emergency Contact (if different from legal guardian): \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

7) Health Insurance Subscriber ID \_\_\_\_\_ Group ID \_\_\_\_\_

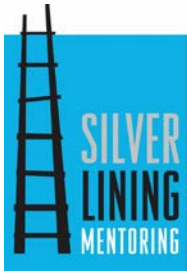
**In case of an emergency, I authorize the Silver Lining staff to seek medical assistance.**

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature/Participant (if 18 or older)

\_\_\_\_\_  
Date



# Silver Lining Mentoring Participant Application

## E. Medical Information Release Form

\_\_\_\_\_  
**Name of Participant**

\_\_\_\_\_  
**Name of Guardian** (if participant is under 18 yrs)

Youth/Participant is older than 18 years old  Yes  No

The Health Insurance Portability and Accountability Act (HIPAA) was created to protect the privacy rights of individuals' personal health information. It affects all those who are in contact with medical records or personal health information. Under this law, staff and volunteer members of Silver Lining Mentoring are restricted from sharing information with others regarding injuries or medical conditions of you/your child unless a release is signed.

As a condition to eligibility to participate in Silver Lining services, guardians/participant (if 18 or older) are required to complete and sign the following statement of disclosure authorization.

I, \_\_\_\_\_ am authorizing **FULL** disclosure of above named participant's  
(print First & Last name)

personal health information in regards to any medical conditions, problems or allergies I/they may have, or any medications or doctor's care that may be prescribed for me/them during the period of my/their participation in any of Silver Lining Mentoring's services and activities, or any injury that I / they may sustain while participating in any such service or activity. My/Their personal health information may be shared with the following individuals:

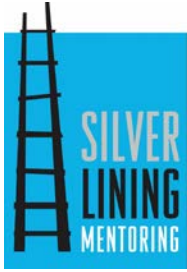
- Silver Lining staff members,
- Silver Lining volunteers,
- any Social Worker to whom participant may be assigned, and
- any medical personnel to whom such child may be brought in the event of an emergency

I understand that I may at any time revoke this authorization in writing. However, by doing so, I understand that I will forfeit my/my child's participation in Silver Lining's services and activities.

I understand that if an unauthorized disclosure has been made, I may file a formal complaint with the United States Department of Health and Human Services.

Signature: \_\_\_\_\_  
Guardian Signature/Participant (if 18 or older)

Date: \_\_\_\_\_



# Silver Lining Mentoring Participant Application

## F. Photo/Media Release & Waiver

I, \_\_\_\_\_, hereby grant Silver Lining Mentoring and its partners permission to use the  
(Guardian/ Participant over 18 yrs)  
following selected items below regarding \_\_\_\_\_ to publicize and promote Silver Lining  
(Participant name)  
Mentoring (e.g., in newsletters, website, etc.).

Please **check AND initial** next to the following items that you will allow Silver Lining Mentoring to publicize:

1) Participant's name:

a) \_\_\_\_\_  First and last name

b) \_\_\_\_\_  First name only

2) Participant's visual image:

a) \_\_\_\_\_  Any visual image (photographic or video images)

b) \_\_\_\_\_  Non-identifying visual images only (e.g. silhouettes, hands, feet, back)

3) Participant's statements:

a) \_\_\_\_\_  (e.g. quotes, stories, written and/or spoken)

4) Participant's artwork:

a) \_\_\_\_\_  (e.g. drawings, art, photography)

I acknowledge that Silver Lining Mentoring or its assignee has total ownership of the program or article in which my above selected information will be used. I understand that I will not receive compensation for the use of such information used to publicize and promote Silver Lining Mentoring.

My consent to this waiver and release signifies that I completely release, promise and covenant not to sue or assert any claims against Silver Lining Mentoring, its personnel, and/or agents of the program for liability that may arise from Silver Lining Mentoring's use of the above selected items for the purposes stated herein. By signing below, I am acknowledging that I have read and fully understood this Release and Waiver and that I consent to the use of the above selected information to publicize and promote Silver Lining Mentoring.

Print Full Name

Date

Signature of Participant

Date

**TO BE COMPLETED BY PARENT/GUARDIAN IF PARTICIPANT IS A MINOR:**

I am the legal guardian of the above-named minor and I agree to the terms of this release and consent to the use such minor's above-selected and initialed information for publicity and promotional purposes.

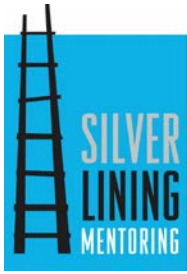
Print Full Name of Parent/Guardian

Date

Signature of Parent/Guardian

Date

Silver Lining Mentoring, 727 Atlantic Avenue, 3<sup>rd</sup> Floor, Boston, MA02111  
Phone: (617) 209-5308 E-mail: victoria@silverliningmentoring.org



# Silver Lining Mentoring Participant Application

## G. Permission Forms

1. **Driving Permission:** *(all participants; required for participant to travel with Silver Lining volunteers or staff)*

For Silver Lining mentors, staff, and volunteers to drive \_\_\_\_\_

Participant Name

**For parent/guardian/social worker to sign:**

Safety while in a car is very important for both drivers and participant/participants. A participants/participant cannot ride in a car with a driver without the participant's guardians or participant's (if 18 or older) consent. If an accident occurs while the driver is engaged in a Silver Lining Mentoring event, he/she should immediately seek appropriate medical attention and promptly report the incident to Silver Lining staff.

**I understand that I had the right to ask any questions before signing this. I do not hold Silver Lining Mentoring responsible for any accident, harm, injury or death that results from driving with the mentor/staff/volunteer driver.**

\_\_\_\_\_  
Guardian signature/Participant (if 18 or older)

\_\_\_\_\_  
Date