



OFFICE USE ONLY	
Program Name	
Enrollment Date	

Welcome to the Latino Network! Please take a moment and complete our enrollment form. Your information is private and confidential. Only Latino Network staff will have access to this information. Thank you!

Child/Youth Last Name:		Middle Name:
First Name:		Date of Birth (MM/DD/YYYY):
Home Address:		
City:	State:	Zipcode:
Cell Phone:	Email:	
School Name:		
Synergy # (Students Only):		Grade:
What is your preferred language? _____		
<i>First Language Spoken at home:</i> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Cantonese <input type="checkbox"/> Hmong <input type="checkbox"/> Mandarin <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Arabic <input type="checkbox"/> Other (please list): _____		
Do you receive Free or Reduced Lunch? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable		
<i>Are you enrolled in one of the following programs? Please check all that apply:</i> <input type="checkbox"/> ELL/ESL/ELD <input type="checkbox"/> Dual-Language Immersion <input type="checkbox"/> Special Ed. <input type="checkbox"/> Talented & Gifted <input type="checkbox"/> Not Applicable		
<i>What is your gender?</i> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Gender Non-conforming <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other (please list): _____		
<i>What is your race or ethnicity? Please check all that apply:</i> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Mexican <input type="checkbox"/> Central American <input type="checkbox"/> South American <input type="checkbox"/> Afro-Latino/a <input type="checkbox"/> Indígena <input type="checkbox"/> Mestizo <input type="checkbox"/> Other Hispanic or Latino (please list): _____ <input type="checkbox"/> Asian <input type="checkbox"/> Burmese <input type="checkbox"/> Karen <input type="checkbox"/> Zomi <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino/a <input type="checkbox"/> Japanese <input type="checkbox"/> South Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Asian: _____ <input type="checkbox"/> Black/African American <input type="checkbox"/> African American <input type="checkbox"/> Somali <input type="checkbox"/> Congolese <input type="checkbox"/> Eritrean <input type="checkbox"/> Other African: _____ <input type="checkbox"/> Caribbean <input type="checkbox"/> North African <input type="checkbox"/> Other Black: _____ <input type="checkbox"/> Indigenous <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Canadian Inuit, Metis, or First Nation <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Tongan <input type="checkbox"/> Chuukese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander _____ <input type="checkbox"/> White <input type="checkbox"/> Slavic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer		
<i>Do you have any conditions/special needs that would warrant accommodations for your participation? Select all that apply:</i> <input type="checkbox"/> Physical Impairment (e.g., loss of extremities, partial or total paralysis, reduced mobility, epilepsy, etc.) <input type="checkbox"/> Auditory Impairment (e.g., hard of hearing, total hearing loss, auditory processing disorder, etc.) <input type="checkbox"/> Visual Impairment (e.g., blind, low vision, etc.) <input type="checkbox"/> Intellectual Disabilities (e.g., ADHD, Autism, Dyslexia, etc.) <input type="checkbox"/> Mental Health Disorder (e.g., Obsessive compulsive disorder, severe anxiety, PTSD, etc.) <input type="checkbox"/> Multiple Disabilities (Examples: deaf-blind, among others) <input type="checkbox"/> Other (please specify): _____		

Parent/Guardian		<input type="checkbox"/> Check if parent is also enrolled in program	
Parent Last Name:		First Name:	
Relationship to Client: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian		Date of Birth (MM/DD/YYYY):	
Address:		<input type="checkbox"/> Please check if same as client	
City:	State:	Zipcode:	
Cell Phone:	Evening/ Work Phone:		
Email:			
What is your preferred language?			
Please circle the number of school years completed:			
1	2	3	4
5	6	7	8
9	10	11	12
College 1		2	3
College 4		Other (please list):	
<i>What is your gender?</i>			
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Gender Non-conforming <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other (please list):			
<i>What is your race or ethnicity? Please check all that apply:</i>			
<input type="checkbox"/> Hispanic or Latino			
<input type="checkbox"/> Mexican <input type="checkbox"/> Central American <input type="checkbox"/> South American <input type="checkbox"/> Afro-Latino/a <input type="checkbox"/> Indígena <input type="checkbox"/> Mestizo			
<input type="checkbox"/> Other Hispanic or Latino (please list): _____			
<input type="checkbox"/> Asian			
<input type="checkbox"/> Burmese <input type="checkbox"/> Karen <input type="checkbox"/> Zomi <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean			
<input type="checkbox"/> Laotian <input type="checkbox"/> Filipino/a <input type="checkbox"/> Japanese <input type="checkbox"/> South Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Asian: _____			
<input type="checkbox"/> Black/African American			
<input type="checkbox"/> African American <input type="checkbox"/> Somali <input type="checkbox"/> Congolese <input type="checkbox"/> Eritrean <input type="checkbox"/> Other African: _____			
<input type="checkbox"/> Caribbean <input type="checkbox"/> North African <input type="checkbox"/> Other Black: _____			
<input type="checkbox"/> Indigenous			
<input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Canadian Inuit, Metis, or First Nation			
<input type="checkbox"/> Pacific Islander			
<input type="checkbox"/> Tongan <input type="checkbox"/> Chuukese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan			
<input type="checkbox"/> Other Pacific Islander: _____			
<input type="checkbox"/> White <input type="checkbox"/> Slavic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer			

HOUSEHOLD INCOME

Although participation in our programs does not require our participants to meet a financial criterion, sometimes our funders ask us to report on the income demographic data of our participants. This information will also help us identify participants who may qualify for additional services that we offer or can refer them to other service providers. If you feel comfortable disclosing your annual income earnings, please **answer the next question**.

What is the total estimated **MONTHLY** income of your household? _____ How many individuals live in your household? _____

If you do **NOT** wish to disclose your income, please mark this box: **I Prefer not to Disclose my Household Income**

OUTREACH INFORMATION

Latino Network provides a continuum of services across the life span. If you would like to be contacted about additional program services available for family members, please check off the age groups that live in your household:

- Expecting mothers
- Children in elementary school
- Children in 8th grade
- Elders 60+ in age
- Children ages 0 – 5
- Children in middle school
- High school-aged youth

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

DIGITAL EQUITY

Do you have a reliable internet connection at home? YES NO

- If **yes**, what devices can you and your family use to connect to the internet at home? *Check all that apply:*

Computer/Laptop Cellphone Tablet Smart TV Other _____

Were any devices provided to you by your school? YES NO

If **yes**, which ones? Computer/Laptop Cellphone Tablet Smart TV Other _____

SELF-ASSESSMENT

Please take a moment to read the following statements and let us know how much you agree with each one. Our goal is to understand how you currently see yourself in relation with each statement. The same statements will be asked at the end of services.

Please select your level of agreement with the following statements using the response options on the right.

1. My culture is a source of strength to me.	Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neutral/ Undecided <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>
2. I am hopeful about my future.	Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neutral/ Undecided <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>
3. I have the power/confidence to determine my own future/my family's future.	Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neutral/ Undecided <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>
4. When I see an injustice, I know where to go/what to do to make a difference.	Strongly Disagree <input type="checkbox"/>	Disagree <input type="checkbox"/>	Neutral/ Undecided <input type="checkbox"/>	Agree <input type="checkbox"/>	Strongly Agree <input type="checkbox"/>

RELEASE OF INFORMATION

I understand that in order to provide my child with the best possible service, it is necessary for Latino Network to give and receive relevant information about my child's strengths and needs. I give permission for Latino Network to share and receive information about my child from the designated public school district my child attends, program funders, SUN, Multnomah, Washington, or Clackamas Counties, and/or the City of Portland. This information may include, but is not limited to, report cards, test scores, attendance and behavior information, and evaluation instruments, and surveys. I understand that personal information provided to the program about my child may not be released to anyone without my written consent, unless it involves my child's safety.

If I am a parent participating in a program with my child, I understand it is necessary for Latino Network to capture information about me, such as the information on this form and in evaluation forms and surveys. I understand that personal information provided to the program about me or my family may not be released to anyone without my written consent, unless it involves my safety.

Parent/Guardian Signature: _____ **Date:** _____

PARTICIPANT AGREEMENT

I hereby give my permission for my child to participate in Latino Network's programs. If I am a parent participating in a program with my child, I also agree to participant in a Latino Network program. I understand that by granting permission to participate in the program, I am releasing Latino Network, its employees, contractors, and volunteers from any liability in the case of any injury or damages incurred during or related to my and my child's participation in the program. I further understand that students will be required to abide by the public school district's behavior and safety guidelines and that Latino Network reserves the right to remove or dismiss students due to behavioral concerns. My child has my permission to keep medications listed above in his/her possession and take them independently. In case of emergency, I give permission for Latino Network to obtain the necessary medical assessment, treatment, and/or procedures for my child and myself. Finally, I give permission to Latino Network, its employees, contractors, and/or volunteers to transport my child to and from activities related to the program such as walking trips, swimming, special excursions to places of interest, public parks, community agency facilities, government facilities, and academic institutions, and any other field trips, including out of state field trips.

I also confirm that all information on this application is correct and complete to the best of my knowledge.

Parent/Guardian Signature: _____ **Date:** _____



**Waiver and In-person Participant Agreement
Addendum to Enrollment Form**

On behalf of myself and my minor child named below, I acknowledge and agree that participation in Latino Network programs and activities (“Programs”) comes with certain risks including, *but not limited to*: (1) personal injury, (2) property damage, and (3) sickness or disease including COVID-19. I voluntarily, for myself and child, accept and assume full responsibility for these risks as well as any and all other risks associated with participation in the Programs.

I further agree to the following:

1. I verify that my child does not have or show any symptoms of COVID-19, including cough, shortness of breath or difficulty breathing, or at least two of the following: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell. I accept, agree and acknowledge that if my child develops these or other related symptoms during the program, or I or my child or anyone in the child’s household tests positive for COVID-19, my child will not be able to further participate and the Programs may be closed at any time, without prior notice, in that event.
2. I agree and accept the risk that the program could be closed at any time based on a person experiencing COVID-19 symptoms, including cough, shortness of breath or difficulty breathing, or at least two of the following: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell, or anyone testing positive for COVID-19.
3. I agree to provide or allow Latino Network to provide my child with an appropriately fitting facemask for use as required by State and County Health guidelines, which they will wear at all required times while participating in the Programs, and understand and acknowledge that my child will not be permitted to if they are not wearing a facemask as required.
4. I accept, acknowledge and understand that Latino Network and its staff will, to the best of their ability, require and enforce all applicable requirements which may assist in offering protection from the COVID-19, as specified in the COVID19 health and safety protocols, including but not limited to social distancing, not sharing supplies, and cleaning and hand washing, but understand the atmosphere of the Programs may not allow perfect enforcement.
5. **WAIVER OF LIABILITY/INDEMNIFICATION: I accept and assume full responsibility for any and all injuries, damages (both economic and non-economic), and losses of any type, which may occur to my child, and I hereby fully and forever release and discharge Latino Network, its employees, officers, directors, contractors and agents (“LN indemnitees”), from any and all claims, demands, damages, rights of action, or causes of action, present or future, whether the same be known or unknown, anticipated, or unanticipated, resulting from or arising out the participation in the Programs. I expressly agree to indemnify and hold LN indemnitees harmless against any and all claims, demands, damages, rights of action, or causes of action, of any person or entity, that may arise from injuries or damages sustained by my child.**
6. I accept, acknowledge and understand that failure to adhere and abide by the Latino Network’s COVID19 health and safety guidelines can result in exclusion from in-person participation.

Parent/Guardian Name (Printed)

Child/Youth’s Name (Printed)

Parent/Guardian Signature

Date

Multnomah County SUN Service System SUN Youth Advocacy

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

Instructions: To validate form, please legibly print student name and provide signature and date.

Student Last Name

Student First Name

I am the Parent and/or Legal Guardian of the above Student, who has enrolled as a "Participant" of the SUN Youth Advocacy Program (SYAP). I give my permission to SUN Youth Advocacy Program agencies to use the Participant's school records to maximize opportunities in the program.

I authorize the release and exchange of information between the following program agencies: **Portland Public Schools, Multnomah County SUN Service System staff, Latino Network**, and other Designated Partners written below.

- Student Name and District Student ID#;
- Grade Level, Course Grades and Grade Point Averages, and Achievement Test Scores;
- Attendance Data and Information;
- Behavior/Discipline Data and Information; and
- Other information regarding education and development

I understand that some information of the Participant (First and Last Name, Date of Birth, ServicePoint ID, and Gender) are visible to other local partners for the purpose of avoiding Participant duplication, identifying students that move into a different school or district, and improving coordination and quality of services provided.

This authorization is voluntary. Students may participate in SYAP whether or not their Parent/Guardian authorizes the release or exchange of information between the school, agencies, and Designated Partners.

Designated Partners for (name of provider agency and subcontract agency if applicable) **are:**

-
-

This permission is effective 7/1/22 to 6/30/23 unless cancelled in writing. My signature indicates that my consent is freely given.

Date

Signature of Parent/Legal Guardian

Those receiving information under this release understand that this information is protected under State and Federal law. They are not authorized to release it to any agency or person not listed in this release without specific written consent by the parent/legal guardian.



CLIENT GRIEVANCE POLICY
SUN YOUTH ADVOCACY PROGRAM

Latino Network respects your right to an orderly process whereby problems, complaints, and disagreements with agency actions and decisions can be considered fairly and quickly. If you have a grievance with Latino Network, you should proceed using the following steps:

1. Discuss the grievance with the Latino Network staff from whom you received services.
2. If you are dissatisfied, ask to speak with the manager of the staff person. If you do not feel comfortable asking the staff person for the name of his/her manager, please contact our office and the receptionist will assist you (503-283-6881). The manager must meet with you within two (2) working days of your request.
3. If the manager and you cannot reach an agreement, ask him or her to provide you with a Client Grievance Form. You may also request the form from the Sandy location receptionist (410 NE 18th Ave., Portland, OR 97232). If you need help filing out the form, ask any staff with whom you feel comfortable for assistance. The completed Client Grievance Form should be submitted directly to the program's Director within five (5) working days of your meeting with the manager.
4. The Program Director will respond in writing to your written grievance within five (5) working days.
5. If you are dissatisfied with the Program Director's response to your grievance, you may submit a written or oral appeal within ten (10) working days to the Executive Director.
6. The Executive Director will review your appeal within the next ten (10) working days from the time you let her know of your concern. The Executive Director's decision is Latino Network's final step in the grievance process. If you are still dissatisfied, it is your responsibility to seek legal counsel.

If you do not take your concern to the next grievance step within the designated time limits, the agency will consider the grievance settled based on the last reply or action. If Latino Network fails to comply with the grievance procedures and prescribed timelines, the client's grievance will automatically advance to the Executive Director.

You are encouraged to file a grievance when you are dissatisfied with any aspect of Latino Network's service delivery. Latino Network will not withhold services, or take any other form of recrimination based on your filing a grievance.

Participant Name (Please Print) Participant Signature Date

Youth Advocate Name (Please Print) Youth Advocate Signature Date



CLIENT CONFIDENTIALITY AGREEMENT
SUN YOUTH ADVOCACY PROGRAM

Latino Network respects your right to confidentiality and requires employees and contractors to exercise the utmost discretion in the sharing of information that has been given on a confidential basis. No information received from you in the context of receiving services will be released outside of Latino Network except in the following instances:

1. When you have given written permission;
2. Need to coordinate services that are provided to you by other agencies who contract with Latino Network;
3. Upon issuance of subpoena by a court of law;
4. When we learn of or suspect past or current elderly/child abuse we are required by Oregon State Law to report it to the proper authorities;
5. Upon receiving information that indicates that you have intentions or are at risk of harming yourself or others;
6. To comply with contractual requirements for program monitoring and evaluation.

Participant Name (Please Print) Participant Signature Date

Parent/Guardian Name (Please Print) Parent/Guardian Signature Date

Youth Advocate Name (Please Print) Youth Advocate Signature Date