



ALLIES
A Program of Purchased
P.O. Box 531965
Indianapolis, IN 46253
(317) 782-5535

Mentee Name: _____ Date: _____

Current Age: _____ Date of Birth: _____

Race: (please mark one):

- Black Asian Caucasian Hispanic Multi-Racial
- Native American Other _____

Parent or Guardian Name: _____

Mentee Guardian's Phone: _____ Mentee Cell: _____

Mentee Address: _____

City: _____ State: _____ Zip code: _____

Mentee Email: _____

Does the mentee work? If yes, where: _____

Location: _____ Work Phone: _____

Is the mentee a student? If yes, where: _____

Probation Officer (if applicable): _____ Phone: _____

DCS Case Manager Name: _____

Phone: _____ Email: _____

List below the names of any other agency that has assisted the potential mentee and/or the family in the past year (Department of Child Services, counseling, SNAP, etc.)

Please fill out the following questions as completely as possible. For every yes answer, please explain in the space provided. This information is requested to assist the ALLIES staff in assessing how appropriate the potential mentee is for the program. All information received will be kept strictly confidential. ALLIES will not release this information to any organizations or individuals without written approval.

How did you hear about this program? _____

If referred, by whom? _____ Relationship: _____

Phone: _____

Why do you think the potential mentee would benefit from having an ally? _____

Describe any particular problems the potential mentee might have. (i.e. emotional, behavioral, mental, social, academic, etc.):

List below any goals the ally and ALLIES program could assist the potential mentee with:

Describe anything else you would like us to know about the potential mentee:

Person filling out this form: _____

Relationship to potential mentee: _____

How long have you known the potential mentee: _____