FOSTER GRANDPARENT/SENIOR COMPANION VOLUNTEER APPLICATION

NAME:_____ BIRTHDATE:_____ AGE:_____

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE #:_____ ALTERNATE PHONE #: _____

EMAIL ADDRESS: _____

RACE: ☐ Black/African American ☐ White ☐ Asian ☐ American Indian/ Alaska Native
☐ Native Hawaiian/ Pacific Islander ☐ Other

ETHNICITY: ☐ Hispanic or Latino ☐ Non- Hispanic or Non-Latino

MEDICARE #:_____ MEDICAID #:_____

YEARS OF SCHOOL COMPLETED:_____ PHYSICAL CONDITION:_____

PREVIOUS OCCUPATION(S):_____

ARE YOU A VETERAN: ( ) Yes ( ) No

DO YOU HAVE FAMILY MEMBERS ACTIVELY SERVING IN THE MILITARY: ( ) Yes ( ) No

DAYS AND TIMES YOU ARE AVAILABLE TO VOLUNTEER: _____

DO YOU HAVE YOUR OWN TRANSPORATION: ( ) Yes ( ) No

ARE YOU ON A BUS ROUTE: ( ) Yes ( ) No

DO YOU HAVE ANY CRIMINAL CONVICTIONS (Other than parking violations and juvenile offenses): ( ) Yes ( ) No

IF YES, PLEASE DESCRIBE:

DO YOU CONSENT TO THE AGENCY PERFORMING, OR ARRANGING FOR A CRIMINAL HISTORY CHECK IN ACCORDANCE WITH THE FEDERAL REQUIREMENTS FOR THE FOSTER GRANDPARENT/SENIOR COMPANION PROGRAM? ( ) Yes ( ) No

HOW DID YOU HEAR ABOUT OUR PROGRAM?_____

REMARKS:_____

_____

_____

I certify that the information furnished above is correct and understand that falsification of information may result in my being deemed ineligible to receive a stipend as a Foster Grandparent or Senior Companion. I understand that a knowing and willful false statement on this form can be punished by a fine or imprisonment or both under Section 1001 of Title 18, U.S.C.

Service is at the discretion of the agency. The nonprofit accepts the service of all volunteers with the understanding that such service is at the sole discretion of the agency. Volunteers agree that the agency may at any time, for whatever reason, decide to terminate their relationship with the agency.

SIGNATURE OF APPLICANT: _____ DATE: _____

SIGNATURE OF INTERVIEWER: _____ DATE: _____

REFERENCE: (Cannot be a relative)

NAME:_____ PHONE NUMBER:_____

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PLEASE EMAIL COMPLETED APPLICATION TO INFO@ECSBIGBEND.ORG
OR MAIL TO 2518 W. TENNESSEE STREET TALLAHASSEE FL 32304

Elder Care Services Use Only

REFERENCE CHECK

DATE:_____ PERSON MAKING CHECK:_____

METHOD OF COMMUNICATION: ( ) Phone ( ) Mail ( ) Unable to Contact ( ) Other

( ) Recommended ( ) Not Recommended

COMMENTS:_____

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