

# Foster Grandparent Program

1380 Greg Street, Ste. 212

Sparks, NV 89431

(775) 358-2768

Fax (775) 358-2783

## VOLUNTEER APPLICATION

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

Name: \_\_\_\_\_ Phone: (h) \_\_\_\_\_ (c) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: (circle one) Married Widow(er) Single Divorced Legally Separated

Number in Household \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Ethnicity: (circle one) Caucasian African American Hispanic Indian Asian

Do you have a valid NV driver's license? \_\_\_\_\_ Mode of Transportation \_\_\_\_\_

Email address \_\_\_\_\_

Physical Condition: (circle one) Excellent Good Fair Poor

Please explain: \_\_\_\_\_

Primary language: \_\_\_\_\_ Other languages: \_\_\_\_\_

How did you hear of the Foster Grandparent Program? \_\_\_\_\_

Why do you wish to become a Foster Grandparent? \_\_\_\_\_

Member of Senior Clubs or Organizations, any hobbies or special skills: \_\_\_\_\_

Available: M T W TH F Mornings \_\_\_\_\_ Afternoons \_\_\_\_\_

### Two character references (not relatives):

<u>Name</u>	<u>Address</u>	<u>City/State</u>	<u>Phone</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____

### Emergency Contacts:

<u>Name</u>	<u>Address</u>	<u>City/State</u>	<u>Phone</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____

(OVER→)

Elvirita Lewis Forum

**INCOME ELIGIBILITY**

In order to receive a stipend a Senior Companion or Foster Grandparent must be at least 55 years of age and cannot have an annual income from all sources, after deducting allowable medical expenses, which exceeds the program's income eligibility guideline for the state in which he or she resides. Annual income is required to be counted for the *past 12 months* for volunteers.

***In all categories below list all sources of income for the volunteer applicant and spouse, if living in same residence.***

<b>Current Income from all sources of Applicant and Spouse, if living in same residence</b>	<b>A. Volunteer's Monthly Income</b>	<b>B. Spouse's Monthly Income</b>	<b>C. Total Monthly Income (A+B)</b>		<b>D. Total Annual Income (C x 12)</b>
Social Security	\$	\$	\$	x 12 mo.	\$
SSI / SSDI	\$	\$	\$	x 12 mo.	\$
Pension	\$	\$	\$	x 12 mo.	\$
Interest/Dividends	\$	\$	\$	x 12 mo.	\$
Other countable income	\$	\$	\$	x 12 mo.	\$
<b>COLUMN TOTALS</b>	\$	\$	\$	x 12 mo.	\$

Allowable deductions for medical expenses, if any. Please note up to 50% of the maximized qualifying amount can be deducted.

Health Insurance Premiums	\$ _____ per month	or	\$ _____ per year
Prescription Drugs	\$ _____ per month	or	\$ _____ per year
Doctor visits/medical bills	\$ _____ per month	or	\$ _____ per year
Other allowable medical costs	\$ _____ per month	or	\$ _____ per year
<b>TOTALS</b>	\$ _____ Total per month		\$ _____ Total per year

**FOR OFFICE USE ONLY:**

Total Household Annual Income: \$ \_\_\_\_\_  
 Minus total allowable medical expense deduction: - \_\_\_\_\_  
 Equals **Total Annual Qualifying Income:** \$ \_\_\_\_\_

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 Senior Companion or Foster Grandparent. *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.*

**VOLUNTEER SIGNATURE**                      **DATE**                      **REVIEWED BY SPONSOR STAFF**                      **DATE**