

SENIOR COMPANION 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 _____ Are you an US Veteran? _____

Physical Condition: (circle one) Excellent Good Fair Poor

Please explain: _____

Primary language: _____ Other languages: _____

How did you hear of the Senior Companion Program? _____

Why do you wish to become a Senior Companion? _____

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

Available: M T W TH F Mornings _____ Afternoons _____

Two character references (not relatives):

Name Address City/State Phone

1. _____

2. _____

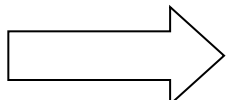
Emergency Contacts:

Name Address City/State Phone

1. _____

2. _____

OVER



SENIORS IN SERVICE INCOME ELIGIBILITY

In order to receive a stipend a Senior Companion 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.

*Income verification requested.

Current Income from all sources of Applicant and Spouse, if living in same residence	A. Volunteer's Monthly Income	B. Spouse's Monthly Income	C. Total Monthly Income (A+B)		D. Total Annual Income (C x 12)
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.	\$ _____
COLUMN TOTALS	\$ _____	\$ _____	\$ _____	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
TOTALS	\$ _____ per month	or	\$ _____ per year
	\$ _____ 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. *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.*

I understand that the volunteer position for which I am applying is contingent on eligibility determined by the results of the NSCHC background check and NSOPW site.

VOLUNTEER SIGNATURE	DATE	SCP VOLUNTEER COORDINATOR	DATE
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