Foster Grandparent Volunteer Application

(Please Print)

DATE_____

LAST NAME_____FIRST NAME_____MIDDLE_____

ADDRESS_____APT #_____

CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____

EMAIL ADDRESS_____

SSN#_____BIRTH DATE_____BIRTH PLACE_____

VECHICLE INSURANCE INFORMATION

DO YOU DRIVE? (Y or N)_____ DO YOU OWN YOUR OWN CAR? (Y or N)_____

DRIVERS LICENSE #_____EXPIRATION DATE_____

IF YES, ARE YOU WILLING TO DRIVE OTHER FOSTER GRANDPARENTS? _____

NAME AND ADDRESS OF AUTO INSURANCE CARRIER_____

_____

EXPIRATION DATE OF INSURANCE_____POLICY # _____

LIABILITY INSURANCE (Y or N)_____

{Please answer the following questions}

How did you learn about the Foster Grandparent Program? _____

_____

Why do you wish to be a Foster Grandparent volunteer? _____

_____

_____

Have you ever worked with children before? (please explain) _____

_____

_____

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Do you have any previous volunteer experience? (please explain) _____

_____

_____

What are your hobbies or interests? _____

_____

_____

Do you have any special skills or interests you would to share when volunteering? (please explain)

_____

_____

List Previous work or occupation_____

_____

Willing to Serve: MORNING _____ AFTERNOON_____ ALL DAY _____

Do you require any special accommodations or have physical or medical considerations that may impact a volunteer assignment?

_____

_____

Have you ever been convicted of a crime other than a minor traffic violation: YES or NO (circle)
If yes please describe the crime and give any details: _____

_____

_____

REFERENCES

(3 people who know you but aren't related)

1. NAME _____ ADDRESS_____
   CITY _____ STATE _____ ZIP CODE_____
   PHONE #_____ EMAIL _____
2. NAME _____ ADDRESS _____
   CITY _____ STATE_____ ZIP CODE _____
   PHONE # _____ EMAIL _____
3. NAME _____ ADDRESS _____
   CITY _____ STATE_____ ZIP CODE_____
   PHONE # _____ EMAIL _____

Foster Grandparent Volunteer Application

(Please Print)

I hereby state that I am 55 years of age or older and offer my services as a volunteer for the Community Action Partnership of Central Illinois Foster Grandparent Program. I understand that I am not an employee of the FGP Project, the sponsor, CAPCIL, the volunteer station or the Federal Government.

APPLICANT'S SIGNATURE _____

DIRECTOR'S SIGNATURE _____
DATE _____

Please return this application, with your income verification from your income source to:

CAPCIL
FOSTER GRANDPARENT PROGRAM
1800 5TH ST. LINCOLN, IL 62656

217-732-2159
btitus@capcil.org
ckincaid@capcil.org

**The following information is optional and will not affect your enrollment with CAPCIL FGP.

1. Occasionally CAPCIL FGP will purchase volunteer recognition gifts to FGP volunteers. Please share the size you would use on each item below:

Item	Size	Item	Size
Jacket		Vest	
Sweatshirt		T-shirt	

2. FGP is often asked to provide demographical information pertaining to volunteer members. Please provide the following information (Optional).

Are you a veteran? _____ Are you an active military member? _____
Are any of your family member's veterans or actively serving? _____

GENDER (M or F)_____ ETHNIC ORIGIN_____MARITAL STATUS (S, M, D or W)_____

SMOKER (Y or N)____ HANDICAP (Y or N)____ HIGHEST GRADE OF EDUCATION_____

----------(**FOR OFFICE USE ONLY**)----------
PRIVATE HOME (Y or N)_____ TRANS. TYPE _____ MILEAGE_____
STATUS _____ ENROLLMENT DATE_____ ORIENTATION DATE _____
ANNIVERSARY DATE_____ RETIREMENT DATE_____
LAST EVALUATION _____ SUPERVISORY EVALUATION DATE_____
CURRENT PHYSICAL (Y or N) DATE_____ TB TEST (Y or N) DATE_____
AUTO INSURANCE UPDATE _____

Income Review Form

Foster Grandparent 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 they reside. Annual income review is required.

Name: _____ Phone: (_____) _____- _____ email: _____

Number in household: _____ ☐ **New volunteer** ☐ **Current volunteer**

Marital Status: ☐**Married** ☐**Widow(er)** ☐**Single** ☐**Divorced** ☐**Legally Separated**

List all sources of income for the volunteer applicant and spouse, if living in same residence.

Current Income from all sources of Applicant and Spouse	**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: see back for list of 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. See reverse side for examples of allowable medical deductions.

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

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/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.*

_____ _____ _____ _____
VOLUNTEER SIGNATURE DATE REVIEWED BY SPONSOR STAFF DATE

FOR OFFICE USE ONLY:

Total Household Annual Income: **$** _____
Minus total allowable medical expense deduction: – _____
Equals **Total Annual Qualifying Income:** **$** _____

Income Review Form

What is considered income for determining volunteer eligibility?
According to Section 2552.44 of the FGP Regulations and 2551.44 of the SCP Regulations:

(a) For determining eligibility, "income" refers to total cash or in-kind receipts before taxes from all sources including:
  (1) Money, wages, and salaries before any deduction, but not including food or rent in lieu of wages;
  (2) Receipts from self-employment or from a farm or business after deductions for business or farm expenses;
  (3) Regular payments for public assistance, Social Security, Unemployment or Workers Compensation, strike benefits, training stipends, alimony, child support, and military family allotments, or other regular support from an absent family member or someone not living in the household;
  (4) Government employee pensions, private pensions, and regular insurance or annuity payments; and
  (5) Income from dividends, interest, net rents, royalties, or income from estates and trusts.

(b) For eligibility purposes, income does **not** refer to the following money receipts:
  (1) Any assets drawn down as withdrawals from a bank, sale of property, house or car, tax refunds, gifts, one-time insurance payments or compensation from injury.
  (2) Non-cash income, such as the bonus value of food and fuel produced and consumed on farms and the imputed value of rent from owner-occupied farm or non-farm housing.
  (3) Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program.

What are allowable medical expenses that may be deducted from income?
According to the FGP Regulations, 2552.43 (c) and SCP Regulations, 2551.43 (c):

Allowable medical expenses are annual out-of-pocket medical expenses for health insurance premiums, health care services, and medications provided to the applicant, enrollee, or spouse which were not and will not be paid by Medicare, Medicaid, other insurance, or other third party pay or, and ***which do not exceed 50 percent of the applicable income guideline.***

Examples of allowable out-of-pocket medical expenses include but are not limited to:
Health Insurance Costs:
Private insurance, Medicare/Medicaid premiums, co-payments and deductibles, long term care insurance

Prescription Drugs:
Pharmacy program co-payments and deductibles

Medical Bills for Dr. Visits:
Included, but not limited to: medical care, dental care, vision care not covered by health insurance

Other out-of-pocket Medical expenses:
One time medical expense: equipment, supplies for dentures, hearing aids, eyeglasses, wheelchairs, canes, etc.. Over the counter drugs and supplies not covered by health insurance: pain relievers, antacids, hearing aid batteries, vitamins, non-prescription eye glasses

Income Review Form

When and where are the current income eligibility guidelines published?

CNCS publishes the annual income eligibility guidelines shortly after the issuance of the HHS Poverty Guidelines, usually in February or early March. When issued the income eligibility guidelines are posted at Senior Corps Resources under "Manage Senior Corps Grants." ***The guidelines clarify that for eligibility purposes, income does not include the value of food stamps provided under the Food Stamp Act of 1977, as amended.***

If you have questions or need further clarification on determining income eligibility, please contact your CNCS State Office.

Community Action Partnership of Central Illinois

ASSIGNMENT*:* *Foster Grandparent* LOCATION: *Assigned Site*
REPORTS TO: Volunteer Services Director CLASSIFICATION: *Volunteer*

SUMMARY OBJECTIVE:

To provide service to children with special and exceptional needs as a role model and/or mentor to improve their physical, mental, emotional and social development. To serve children in school, child care, Head Start and institutional settings.

RESPONSIBILITIES:

1. Assist children with assigned activities developed by volunteer station staff.
2. Provide a supportive relationship with the children served.
3. Interact with children in a developmentally appropriate manner using positive discipline techniques.
4. Willingness to take supervision from program and volunteer station staff.
5. Ability to report to volunteer station promptly and on a regular basis.
5. Maintain confidentiality of all information regarding children, families and staff.
6. Attend all in-service trainings and orientations required by the federal grant.
7. Willingness to be a positive role model/mentor to children (communication, hygiene, appearance, etc)
8. Willingness to accept change in assignment or volunteer location, if needed

QUALIFICATIONS:

1. Must be at least 55 years of age or older.
2. Must reside in Logan, Macon, Mason, Piatt, DeWitt, Fulton, or Menard Counties.
3. Meet income requirements established by federal grant guidelines.
4. Successfully complete fingerprint and background check including FBI, State and NSOPW.
5. Must be willing to volunteer consistently 20, 30, or 40 hours per week.
6. Must complete annual physical examination and receive health clearance from doctor.

Please note this volunteer description is not designed to cover or contain a comprehensive listing of activities or responsibilities. Regulations, responsibilities and activities may change at any time with or without notice.

I certify that I have read and understand the above volunteer description.

_____ _____
Volunteer Signature Date