FOR OFFICE USE ONLY
Received by: _____ Date: ____/____/____
Background Check Initiated: ____/____/____
Background Check Done: ____/____/____
Orientation by: _____ Date: ____/____/____
Assignment(s): _____

AMERICORPS SENIORS VOLUNTEER APPLICATION FORM

Name_____ **Birth Date**_____ **Age**_____

Mailing Address_____ **City**_____ **Zip**_____

Phone _____ **Cell** _____ **Email** _____

Driver's License _____ **State** _____ **Expires** _____/_____/_____
Attach a copy of your driver's license and auto insurance coverage.

Emergency Contact_____ **Phone**_____

How did you hear about us? □ Friend □ Postcard □ Radio □ Newspaper □ Other_____

If referred by current volunteer, list name _____

POSITION & AVAILABILITY

I am interested in becoming: □ Foster Grandparent □ Senior Companion □ Both

Days Available: □ Mon □Tues □ Wed □ Thu □ Fri □ Sat □ Sun

Time Available: □ Mornings □ Afternoons □ Evenings

INCOME REVIEW

INCOME REVIEW The annual income of all volunteers must be verified to determine eligibility.

Marital Status: □ Married □ Domestic Partner □ Widowed □ Single □ Divorced □ Separated
Number of people in your household: _____

List <u>all</u> sources of gross income only from those in the household legally mandated to provide family support (Ie: spouses). **<u>SSDI</u> or <u>SSI</u> payments <u>DO NOT</u> count as income.**

MONTHLY INCOME:

Social Security Benefits $ _____
Pension $ _____
Interest / Dividends $ _____
Other: _____ $ _____
_____ $ _____

Total Monthly Income: $ _____

MONTHLY MEDICAL EXPENSES:

Health Ins./Medicare premiums: $ _____
Prescription drugs $ _____
Doctor visits / medical bills $ _____
Dental/Vision/Mobility bills $ _____
Other: _____ $ _____
_____ $ _____

Total Medical Deductions: $ _____

EXPERIENCE

The following information will help match you with a volunteer opportunity.

Employment Experience _____

Special Skills/Interests/Languages _____

Volunteer Experience _____

INSURANCE

AmeriCorps Seniors volunteer is covered by accident/personal liability insurance plus a small death benefit while performing volunteer duties. This coverage is automatic and of no cost to you while an active, enrolled member of AmeriCorps Seniors. Please provide the following information:

Beneficiary for Supplemental Accident Insurance:

Name_____ **Relationship**_____

Address_____**Phone**_____

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read and understood the following statements:

- I hereby state that I am 55+ years of age and offer my services as a volunteer for the Central & Eastern Oregon FGP/SCP Program. I understand that I am not an employee of AmeriCorps Seniors, the sponsor, the counties, the volunteer station or the Federal Govt.
- I understand that in my capacity as a volunteer, I may encounter confidential information. I agree to protect this information to the best of my ability and not to disclose it during or after my service as a volunteer has ended.
- I understand that if I use my personal automobile in my volunteer service, I will arrange to keep automobile liability insurance equal or greater to the minimum requirements of the state of Oregon. I will also keep in effect a valid Oregon State Driver's license.
- I understand that I will be required to obtain fingerprints and pass a background check.

Instructions on how to complete the background process will be emailed to you upon application approval.

_____ _____

Signature **Date**

I certify that the information furnished above is correct and understand that falsification of information may result in being deemed ineligible to receive a stipend. 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.

Return completed application to:

AmeriCorps Seniors
PO Box 1602
Pendleton, OR 97801

Questions contact:
(541) 276-7064
fgpscpinfo@ccsemail.org