



VOLUNTEER APPLICATION

Foster Grandparents are role models, mentors, and friends to children with exceptional needs. They help children in their communities develop the academic and life skills that are critical to their development and future successes. Grandparents communicate with and tutor assigned children to facilitate constructive person-to-person relationships. They are encouraged to provide warm friendship, interests, understanding, individualized attention and unhurried help as required by the needs of a child. They serve in community organizations such as schools, daycare centers and the Head Start Program.

Senior Companions are volunteers who help and provide friendship to seniors who have difficulty with daily living tasks, such as shopping, paying bills or driving. They provide companionship and support to those who are lonely and isolated. The program aims to keep seniors independent longer and to provide assistance to family caregivers. Senior Companions are encouraged to provide weekly individualized visits to their clients. The program receives referrals from agencies that provide social services within the community.

Time Commitment: Volunteers are encouraged to give 20 – 40 hours per week (minimum of 260 hours per year or 5 hours a week; maximum of 40 hours per week; no more than 8 hours per day).

Program Area: FGP volunteers are recruited throughout Eastern and Central Oregon; SCP volunteers are recruited in the Eastern Oregon service area. Our main office is in Pendleton.

Stipend / Other Benefits: Volunteers receive a stipend of \$4.00 per hour to cover any expenses associated with volunteering. The stipend is non-taxable and is not considered income when computing income for other federal/state program eligibilities. In addition, volunteers receive mileage reimbursement to and from volunteer sites, orientation, in-service training, and insurance coverage (accident, liability, & excess auto insurance) while serving as a volunteer.

Eligibility: To become a Foster Grandparent or Senior Companion volunteer, one must:

- Be at least 55 years of age.
- Pass a background check. Participation is contingent upon a criminal history review.
- Not exceed the following income guidelines:

1-person household -- \$2510 monthly	2-person household -- \$3407 monthly
3-person household -- \$4303 monthly	4-person household -- \$5200 monthly

* * We can consider medical, dental, and prescription drug bills, and also health insurance costs when determining eligibility.

AmeriCorps Seniors of Eastern & Central Oregon
P.O. Box 1602
Pendleton, OR 97801
Phone: 541-276-6074 **Fax:** 541-276-4474
E-mail: fgpscinfo@ccsemail.org
Physical Address: 221 S. Main St. Ste 4 (Pendleton)



PERSONAL INFORMATION

Name: _____ Date: _____
First MI Last

Address: _____
Street City State Zip

Telephone: _____ Cell _____ Do you text? [] Yes [] No

Email: _____ Birthdate: ____/____/____
(Required)

Emergency Contact: _____
Name Relationship Phone

Previous Occupation(s): _____

List Memberships in Clubs and Organizations, Hobbies & Special Skills:

US Standard Demographic Questions.

Used to foster our commitment to Diversity, Equity, Inclusion, and Accessibility.

How did you hear about us? [] Friend [] Internet [] Referral [] Newspaper [] Other _____

Were You Referred to by a Current Volunteer? [] No [] Yes, Who? _____

Are You a Military Veteran? [] Yes [] No

Language(s) Spoken: [] English [] Spanish [] Other: _____

Racial/Ethnic Background (check one): [] Indigenous/American Indian or Alaskan Native [] Black or African descent
[] Asian [] Hawaiian or Pacific Islander [] White or European [] Hispanic/Latinx or Spanish [] Multi-Race (2 or more)
[] Other _____ [] Prefer not to answer

How would you describe your gender identity: [] Woman [] Man [] non-binary [] Gender Variant/Non-Conforming
[] Prefer to self-describe _____ [] Prefer not to answer

Sexual Identity/Sexual Orientation (check one): [] Asexual [] Bisexual [] Gay [] Heterosexual or straight [] Lesbian
[] Pan Sexual [] Queer [] Other _____ [] Prefer not to answer

Do you identify as Transgender: [] Yes [] No [] Prefer to self-describe _____ [] Prefer not to answer

VOLUNTEER INFORMATION

Volunteer Position: [] Foster Grandparent [] Senior Companion

Time Commitment (check one): [] 6 mo. [] 1 Year [] Indefinitely [] Other _____

Day Availability: M T W TH F S SU Time Availability: [] Mornings [] Afternoons [] Evenings

Transportation Source: [] Private Car [] Carpool [] Public Transportation [] Walk [] Bike [] Taxi

Claiming Mileage Reimbursement? [] Yes [] No If yes, please provide the following:

Driver's License # _____ State: _____ Expiration Date: _____

All information on this application is true to the best of my knowledge. I release, indemnify and hold harmless Community Counseling Solutions, its officers, agents and employees from any and all claims, actions and demands that may arise from my actions as a volunteer. I also understand that my volunteer involvement can be terminated at the discretion of the agency at any time. I understand that if I use my personal vehicle to and from or during my volunteer placement, that I am agreeing to keep in effect automobile liability insurance equal to or greater than the minimum required by the state of Oregon.

Signature

Date



PERSONAL REFERENCES

Personal references will be contacted by phone during daytime business hours. Please list individuals who know you personally, preferably not related to you.

Name Relationship Phone

Name Relationship Phone

DESIGNATION OF BENEFICIARY

Senior Corps Programs provide free volunteer liability, excess accident medical and excess automobile liability insurance coverage to volunteers while providing their service.

In the case of your death, please designate below the person you wish to receive your final stipend or other monies due you. By naming a person below, you are directing the FGP-SCP Program of CCS to send your final stipend or other monies due you in a check made out to the person who is listed as the beneficiary below. A beneficiary could be a family member, a friend, or anyone else you designate.

Name: _____ Relationship: _____ Phone: _____

Address: _____
Street City State Zip

CONFIDENTIALITY STATEMENT

Confidentially is the preservation of privileged information concerning a client and/or a child, which is disclosed in a professional working relationship. Part of what volunteers learn is necessary to provide services to clients and/or children; other information is shared within the development of a helping, trusting relationship. Therefore, most information gained about individuals and their families throughout an assignment is confidential in terms of the law, and disclosure would make you legally liable. Disclosure could also damage your relationship with the client or child/school and make it difficult to help the person.

All records dealing with specific clients or children must be treated as confidential. General information, policy statements or statistical material not identified with any family is not classified as confidential.

My signature below certifies that I have read the above information. I understand my duty as a volunteer of Community Counseling Solutions to abide by laws and policies regarding the preservation of confidential information.

Signature Date

DO NOT WRITE BELOW

FOR OFFICE USE ONLY:
Date Received _____ Volunteer Placement _____ Staff Initials _____
Background check sent _____ Background check received _____ Orientation _____



INCOME REVIEW

The Foster Grandparent/Senior Companion Program is required to verify annual income check on all volunteers participating in this program. Please fill out the entire form as completely as you can. This information is kept strictly confidential *** **SSDI** or **SSI** payments also do not count as income. ***

Marital Status: Married Domestic Partner Widowed Single Divorced Separated

Number of persons in your household: _____

Time Period Reviewed: Previous 12 months

List all sources of gross income before any deductions. You must include income from all adult household members.

INCOME:

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

Total Income: \$ _____ / month

OUT OF POCKET MEDICAL EXPENSES:

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

Total of Medical Expense Deductions: \$ _____ / month

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.

Signature

Date

FOR OFFICE USE ONLY:

Total Household Monthly Income: _____
 Total Allowable Medical Expense Deductions: _____
 Adjusted Total Monthly Income: _____ X 12 = _____
Total Yearly Income



AmeriCorps Seniors Volunteer Application



BACKGROUND CHECK AUTHORIZATION FORM

As required with my application I understand and authorize Community Counseling Solutions to conduct a national criminal record check via the Background Check Unit (BCU), which requires fingerprinting. I understand an abuse check will be completed on me. I authorize without reservation; any party or agency contacted to furnish the above-mentioned information and release all parties involved from any liability and responsibility for doing so. I understand the program may request and receive information regarding my juvenile, police, court, or investigation reports. Results will be used in determining the selection of the volunteer for placement with the program. I understand that I may challenge the results of this inquiry. I understand the background check may be repeated at any time and without notice during my time as a volunteer.

Signature Date

Please print clearly to ensure an appropriate check is completed:

Legal Name: _____ Maiden Name: _____
 First MI Last

Other Aliases or Names Used: _____

Soc. Sec. #: _____ - _____ - _____ Place of Birth: _____
 City State

Current Address: _____
 (Physical) Street City State Zip

County: _____ How long: _____ to _____

Previous Address: _____
 Street City State Zip

County: _____ How long: _____ to _____

During the last five (5) years, have you been outside of Oregon for 60 days in a row or more? Yes No
 If yes, complete the following for each residence in the past 5 years:

Start Date	End Date	City	State	County	Name(s) used if different

Have you ever been charged, arrested, and/or convicted of a crime? Yes No
 If you answered yes, list all charges, arrests, and/or convictions (adult and juvenile) and the outcome.

Date	Charge or Arrest	Outcome*	City	County	State

*(for example, conviction; dismissal)

If provide additional information here if you have potentially disqualifying convictions or conditions:

Please return completed applications to: **AmeriCorps Seniors P.O. Box 1602 Pendleton, OR 97801**
 or scan/email to fgpscinfo@ccsemail.org
 or Fax **541-276-4474**

Include the following to avoid delay:
Copy of Photo ID (Driver's License or another ID Card *with photo*)
Copy of current Auto Insurance Card (if claiming mileage)

INSTRUCTIONS FOR FINGERPRINTING WILL BE SENT TO YOU ONCE YOUR APPLICATION AS BEEN APPROVED.