VOLUNTEER APPLICATION SENIOR COMPANION PROGRAM

AACOG Alamo Area Council of Governments

AmeriCorps Seniors

Please fill in the following basic information:

First Name: _____ MI: ____ Last Name: _____

Address: _____

City: _____State: _____ Zip:_____ County:_____

Home Phone: _____ Cell Phone:_____

Email: _____

Birthdate: _____ Birthplace: _____

Personal References:

Reference #1 (not related): _____ Phone: _____

Reference #2 (not related): _____ Phone: _____

Experience:

Do you have any caregiver experience? Yes_____ No_____

If yes please describe:_____

_____

This volunteer position may require any or all of the following: prolonged sitting, standing, bending/stooping, climbing stairs, and walking. How well do you feel you can perform these duties?

__Very Well __Good __Fairly Well __Not Very Well

Language Abilities

What is your primary spoken Language:		What is your primary written language:
If English is not your primary language, how well would you rate your English Skills?		
☐ Read	Proficiency Level:	☐ Low ☐ Fair ☐ Adequate ☐ Proficient ☐ Fluent
☐ Speak	Proficiency Level:	☐ Low ☐ Fair ☐ Adequate ☐ Proficient ☐ Fluent
☐ Write	Proficiency Level:	☐ Low ☐ Fair ☐ Adequate ☐ Proficient ☐ Fluent
☐ Translate	Proficiency Level:	☐ Low ☐ Fair ☐ Adequate ☐ Proficient ☐ Fluent

When are you able to serve? Mornings_____ Afternoons_____ Evenings_____

What is your preferred number of hours per week? _____

Transportation: ___ I have my own transportation ___I do not have transportation

SENIOR COMPANION PROGRAM SERVICE AGREEMENT

I am willing to serve as a volunteer in the Senior Companion Program sponsored by AmeriCorps Seniors and Alamo Area Council of Governments. I understand the typical assignment will be 5 - 40 hours per week. And that I will have the following benefits:

1. A non-taxable stipend of $4/hour which will be electronically deposited into my bank account.
2. Annual leave and Sick leave.
3. Holiday pay based on the holiday observance schedule established by AACOG and the stipulations in the senior companion handbook.
4. On-duty supplemental accident insurance.
5. An annual recognition event, and
6. Mileage reimbursement for the use of my personal vehicle to and from my assignment and while transporting to the store or doctor appointments, etc. of .50 per mile, which will be electronically deposited with non-taxable stipend.

I also understand that I am required to attend in-service training sessions and official Senior Companion events. In case of illness, I will contact the Outreach Specialist as soon as possible.

_____

Applicant Name (Print)

_____ _____

Applicant Signature Date

VOLUNTEER CONFIDENTIALITY AGREEMENT

If selected for the Senior Companion Program, I will be serving beneficiaries over the age of 60 and I will have knowledge of the medical conditions, home and family life and personal issues. I understand that I am bound by the confidentiality laws during and after my service with the Senior Companion Program regarding my client, the staff of the Senior Companion Program, other volunteers and clients. I understand that the unauthorized disclosure of confidential information could result in my prosecution under state and/or federal laws. Furthermore, any such disclosure could result in my immediate termination from the program.

By my signature below, I agree to keep all information that I have knowledge of regarding my clients, the staff, other volunteers, and clients confidential.

_____ _____

Applicant Signature Date

RELEASE

Because the Senior Companion Program can better serve Beneficiaries through improved public awareness generated by printed materials, displays, videos, photographs, television, radio and/or press, I hereby give my consent to use my name, case history and photograph for publicity purposes.

____ I AGREE TO THESE TERMS AND GIVE MY PERMISSION FOR THE USE DESCRIBED ABOVE.

____ I DECLINE TO GIVE PERMISSION FOR THIS USE

_____
Applicant Name (Print)

_____ _____
Signature Date

Address: _____ Phone: _____

City: _____ State: _____ Zip: ____ County:_____

CONSENT TO RELEASE INFORMATION

_____If selected for the program, I hereby authorize the Program to print my name, address, phone number and Birthday in the Program Directory. I understand that the information will be released to the employees and volunteers of the program for networking purposes. I understand that this information will not be released to outside entities or shared with any other persons without my specific written consent. By signing below, I agree to this statement and to have my information printed in the program directory. Furthermore, I agree to keep this information confidential. I will not release the contents of the directory to anyone not associated with the Program.

_____If selected for the program, I hereby request that my personal information be withheld and not printed in the Directory. I hereby agree to keep confidential any information I receive in the directory and will not release the contents of the directory to anyone not associated with the Program.

_____ _____
Applicant Signature Date

SCP VOLUNTEER INCOME VERIFICATION FORM

In order to receive a stipend, A Senior Companion Volunteer must be at least 55 years old and must be at 200% or below the Federal poverty level from all sources, after deducting allowable medical expenses. Annual income is required to be counted for the past 12 months for currently serving volunteers and is projected for the next 12 months for new applicants.

___Current Volunteer ___ New Applicant

First Name: _____ MI:____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: ____ County:_____

Home Phone:_____ Birthdate:_____

MARITAL STATUS: __Married __Widowed __Single __Divorced __Legally Separated

Number of people in Household: _____

List Maiden Name and Any Other Names Used: _____

_____

_____ _____

Applicant/Volunteer Signature Date

Please provide documentation of all income listed below.

Current income from all sources for Volunteer 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 (Cx12)
Social Security	$	$	$	$
SSI/SSDI (disability income)	$	$	$	$
Pension	$	$	$	$
Interest/Dividends	$	$	$	$
Other (see next page)	$	$	$	$
TOTAL INCOME	$	$	$	$
Deductions for medical expenses, if any. Up to 50% of the maximized qualifying amount can be deducted in order to meet program income limits. See next page for examples of allowable medical deductions.				
Health Ins Premiums	$	per month or	$	per year
Prescription Drugs	$	per month or	$	per year
Dr. Visits /medical bills	$	per month or	$	per year
Other allowable medical expenses	$	per month or	$	per year
TOTAL MEDICAL EXPENSES	$	per month or	$	per year

I certify that the information above is correct, and I understand that the falsification of information may result in my being deemed ineligible to receive a stipend as a volunteer in this program. I understand that a knowing and willful false statement on this form can be punished by a fine or imprisonment or both under Section1001 of Title 18 U.S.C.

_____ _____

Volunteer Signature Date

FOR OFFICE USE ONLY:

Total Household Annual Income for _____ $_____

Less: Allowable Medical Expenses $_____

Total Annual Qualifying Income in _____ $_____

Maximum Allowable Income Under CNCS Guidelines for _____ $_____

____Income Eligible for Program for _____

____Not Income Eligible for Program for _____

_____ _____

SCP/AACOG Staff Date

What is considered income for determining volunteer eligibility?

According to Senior Companion Program regulations:

(a) For determining eligibility, "annual income" refers to total cash or in-kind receipts before taxes from all sources for the applicant and that of his/her spouse, if the spouse is lives at the same residence. The Senior Companion Program is also required to count the value of shelter, food, and clothing, if they are provided at no cost by persons related to the applicant, enrollee, or spouse. Examples of income include:
   1) Money, wages, and salaries before any deductions, but not including food or rent in lieu of wages.
   2) Receipts from self-employment or from a farm of 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 or 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) Food stamps.

What are allowable medical expenses that may be deducted from income?

According to the Senior Companion Program Regulations:

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 payer and ***which do not exceed 50 percent of the applicable income guideline.***

Examples of allowable out-of-pocket medical expenses:

Health Insurance Costs: Medicare/Medicaid premiums, co-payments and deductibles, long term care insurance.

Prescription Drugs: Pharmacy program co-payments and deductibles.

Medical Bills for Doctor Visits: Included, but not limited to, medical care, dental care, vision care.

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 (pain relievers, antacids, hearing aid batteries, vitamins, non-prescription eyeglasses)

NATIONAL SERVICE CRIMINAL HISTORY CHECK (NSCHC)

Candidate: _____ DOB: _____

Senior Companion Program

Recurring Access to Vulnerable Populations? __Yes __No

Date Volunteer Began Service (Including pre-service training): _____

___Verify Identity through Government-issue photo identification and obtain consent from the candidate to perform a criminal history check.

COPY OF DRIVER'S LICENSE OR OTHER GOVERNMENT ISSUED ID GOES HERE

Date Identity Verified

_____

Volunteer Consent for Criminal Background Check

"I hereby give my permission for the Alamo Area Council of Governments to obtain information to my criminal history record through TrueScreen and Fieldprint and other sources as necessary. The criminal history record, as received from the reporting agency, may include arrest and conviction data as well as plea agreements and deferred adjudications. I understand that this information may be used, in part, to determine my eligibility for a volunteer position with this program. I understand that as long as I remain as a volunteer with this program, the criminal history check may be repeated at any time. I understand that I will have an opportunity to review the criminal history and that a procedure is available for clarification if I dispute this record as received."

"I, the undersigned, do, for myself, my heirs, executors and administrators, hereby remise, release and forever discharge and agree to indemnify the Alamo Area Council of Governments and each of its officers, directors, employees and agents harmless from and against any and all related attorneys' fees, court costs, and other expenses resulting from the investigation of my background in connection with my application to become a volunteer with this program."

_____
Applicant Name (Print)

_____ _____
Applicant Signature Date