



**FOSTER GRANDPARENT OR SENIOR COMPANION
APPLICATION AND ELIGIBILITY FORM
TROUP COUNTY HEALTH DEPARTMENT**

Print Name: _____ Phone: (____) ____-____ Birth Date: __/__/__

Address: _____
Street City State Zip

Years of School Completed _____

Physical Condition: Excellent- Good- Fair- Poor-

Please Explain: _____

Contact in case of Emergency:

Name: _____

Address: _____ Phone# _____

Relationship: _____

Physician:

Name _____ Phone# _____

Do you wish to be a Foster Grandparent (working with children) or a Senior Companion (working with the elderly)? **Circle One:** Foster Grandparent Senior Companion

Tell why you wish to be a Volunteer? _____

Do you have your own means of transportation? Yes No

List Hobbies and Special Skills: _____

Willing To Serve: Mornings- Afternoons- Evenings- Saturdays- Sundays-

Check any week day you are unable to serve: Mon- Tues- Wed- Thurs- Fri-

Signature

Date

(Over)

(Revised 9/10)

Name: _____ Phone: (____) ____ - ____ Birth Date: ____/____/____

Address: _____
 Street City State Zip

Number in household: _____

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

In all categories below 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, 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: 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
	\$ _____ 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 Foster Grandparent. *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 SIGNATURE OF SPONSOR STAFF REVIEWER DATE

Please submit completed application and income eligibility form, to:
 Senior Corps Programs
 Attn: Patricia Robinson
 900 Dallis Street, Suite A, LaGrange, GA 30240