NORTH COAST OPPORTUNITIES, INC.
FOSTER GRANDPARENT
413 North State Street, Ukiah, CA 95482 | (707) 462-1959

APPLICATION

NAME: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

PHONE: _____ E: MAIL: _____

BIRTHDATE: _____ MARITAL STATUS: _____

ARE YOU A VETERAN? ☐ YES ☐ NO PREVIOUS OCCUPATION: _____

DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT REQUIRE SPECIAL ACCOMODATIONS?

☐ YES ☐ NO IF YES, PLEASE EXPLAIN: _____

_____

_____

CHARACTER REFERENCES

1. NAME: _____

PHONE: _____ E: MAIL: _____

2. NAME: _____

PHONE: _____ E: MAIL: _____

WHEN ARE YOU AVAILABLE TO VOLUNTEER?

☐ MORNINGS ☐ AFTERNOONS ☐ EVENINGS

☐ SAT ☐ SUN ☐ MON ☐ TUES ☐ WED ☐ THUR ☐ FRI

HOW DID YOU HEAR ABOUT THE PROGRAM?

☐ NEWSPAPER ☐ TV ☐ INTERNET ☐ FLYER/BROCHURE ☐ RADIO

☐ FOSTER GRANDPARENT: _____ ☐ OTHER: _____

be the change! Volunteer Network

AmeriCorps Seniors

WHY WOULD YOU LIKE TO BE A FOSTER GRANDPARENT?

_____

_____

_____

HOBBIES & INTERESTS:

_____

_____

_____

ARE THERE ANY PAST VOLUNTEER EXPERIENCES YOU'D LIKE US TO KNOW ABOUT?

_____

_____

ARE YOU INVOLVED IN ANY OTHER CLUBS/ORGANIZATIONS YOU'D LIKE US TO KNOW ABOUT?

_____

_____

_____

INCOME ELIGIBILITY

THE FOSTER GRANDPARENT PROGRAM IS REQUIRED BY THE CORPORATION FOR NATIONAL SERVICE TO MAKE INCOME VERIFICATIONS ON ALL FOSTER GRANDPARENTS IN THIS PROGRAM, UPON THE TIME OF APPLICATION AND ANNUALLY THEREAFTER. PLEASE LIST ALL SOURCES OF INCOME AND BE AS ACCURATE AS POSSIBLE. THIS INFORMATION WILL BE KEPT CONFIDENTIAL

MONTHLY HOUSEHOLD INCOME

SOCIAL SECURITY BENEFITS FROM SSI	$ _____
INCOME FROM PENSIONS	$ _____
NET INCOME FROM RENTALS	$ _____
INCOME FROM STOCKS AND BONDS	$ _____
PUBLIC ASSISTANCE	$ _____
OTHER INCOME	$ _____
MINUS MEDICAL DEDUCTIONS	- $ _____
TOTAL MONTHLY INCOME	$ _____

AUTOMOBILE INSURANCE

(PLEASE FILL THIS OUT ONLY IF YOU PLAN ON DRIVING TO YOUR SITE)

AUTO INSURANCE COMPANY: _____ POLICY NUMBER: _____

POLICY EXPIRATION DATE: _____/_____/_____

DRIVER'S LICENSE NUMBER _____ STATE ISSUED: _____

DRIVER'S LICENSE NUMBER EXPIRATION DATE: _____/_____/_____

MEDICAL INSURANCE

MEDICAL INSURANCE COMPANY: _____ POLICY NUMBER: _____

NAME OF PRIMARY CARE PROVIDER: _____

PHONE: _____

IN CASE OF EMERGENCY

EMERGENCY CONTACTS:

1. NAME: _____ RELATIONSHIP: _____

PHONE: _____ E: MAIL: _____

2. NAME: _____ RELATIONSHIP: _____

PHONE: _____ E: MAIL: _____

DESIGNATION OF BENEFICIARY (FOR SUPPLEMENTARY INSURANCE):

(PLEASE LIST ONE RELATIVE IF POSSIBLE)

1. NAME: _____ RELATIONSHIP: _____

PHONE: _____ E: MAIL: _____

2. NAME: _____ RELATIONSHIP: _____

PHONE: _____ E: MAIL: _____

I CERTIFY THAT ALL THE INFORMATION ON THIS APPLICATION PROVIDED BY ME IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

VOLUNTEER SIGNATURE: _____

VOLUNTEER PRINT: _____ DATE: _____

FOR OFFICIAL USE ONLY:

ASSIGNED SITE: _____

SUPERVISOR NAME: _____ **ROUNDTRIP MILEAGE TO SITE:** _____

NCO STAFF SIGNATURE: _____ **DATE:** _____