Federation of Organizations

SENIOR COMPANIONS
Make Independence a Reality

Application/Enrollment Form
-Please Print-

3390 Route 112, Building A, Medford, NY 11763
Tel. (631) 321-8229 Ext. 1206, Fax: (631) 321-6325

Name: _____ Sex: M_____ F_____

Address: _____ Birth date: _____/_____/_____

_____ E-Mail Address _____

Telephone #: _____-_____-_____ Social Security #: _____-_____-_____ Age _____

Ethnic Group *(Voluntary, for statistical reporting only):* ____Caucasian ____African-American

____Hispanic ____Native American/Alaskan Native ____Asian/Pacific Islander Other_____

Marital Status: Married____ Single____Divorced____Widowed____ Are you a U.S. Veteran? Yes or No

Do you have any family members actively serving in the military? YES or NO

Educational Background: _____ Previous Occupation:_____

Do you drive/own a car? Yes_____ No_____
If not, how do you plan on getting to your volunteer placement? _____

Have you ever worked with the elderly? Yes_____ No_____

If yes, in what capacity? _____

Do you have any criminal convictions (other than parking violations and juvenile offenses)? Yes_____No_____
**Please be advised that all volunteers are required to undergo a criminal background check(expenses covered by the program) prior to enrollment..*

If yes, please describe_____

Please list any hobbies, skills, or talents: _____

Are you bi-lingual? Yes _____ No _____ If yes, what language(s) do you speak? _____

Where did you hear about the Senior Companion Program? (Please check one):

Newspaper Ad ____ TV ____ Friend ____ (Name _____) Other _____

What qualities do you possess that make you feel you would be a successful Senior Companion?

_____

Please list any memberships/clubs/organizations you belong to:

_____

Primary Care Physician: _____

Address:_____Phone:_____

Please list TWO references below (not relatives):

1. _____ _____-_____-_____
   Name Relationship to candidate Phone #

2. _____ _____-_____-_____
   Name Relationship to candidate Phone #

Name of Beneficiary: _____ Relationship:_____

Address_____ Phone: _____-_____-_____

FOR OFFICE USE ONLY

ANNUAL INCOME SOURCES AND AMOUNTS FOR CURRENT YEAR:

Social Security: $_____ Verified by:_____

Pension/Retirement: $_____ Verified by:_____

Stocks/Bonds: $_____ Verified by:_____

Other (explain): $_____ Verified by:_____

TOTAL: $_____

DEDUCTIONS: $_____ = ANNUAL INCOME: $_____

Total number of persons in household _____

Staff Initials:_____ Applicant's Initials:_____ Date:_____

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Annual Out of Pocket Expenses:

Health Ins. Prem $_____

Prescription Drugs $_____

Doc. Visits/ Med Bills $ _____

Other $_____

TOTAL$ _____

Please be aware that we will not discriminate against SCP volunteers or in the operation of its program on the basis of race, color, national origin, gender, sexual orientation, religion, age, disability, political affiliation, marital or parental status, or military service.

By signing below, I certify that the above information is correct and understand that falsification of information may result in termination from the program. I also understand that if I use my personal automobile to and from my volunteer work station, I will arrange to keep in effect automobile liability insurance equal to or greater than the minimum required by the state.

I understand that all Senior Companions are mandated to undergo a criminal background check, NSOPR check and a FBI fingerprint check as per our federal funding guidelines, and I am aware that the results are kept confidential. I understand that I may begin my volunteerism prior to the processing of my background check results; however Federation of Organizations reserves the right to deny continued participation in the program after the results have been received and reviewed.

Signature:_____ **Date:**_____