Foster Grandparent Program – Charles City
PO Box 63
705 3rd Avenue
Charles City, IA 50616
641-257-6327

FOSTER GRANDPARENT PROGRAM APPLICATION

Please Print and Complete all Sections

Last Name _____ First Name _____ Sex M ____ F ____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Date of Birth _____

Number of children _____ Number of Grandchildren _____ Number of Great Grandchildren _____

Marital Status: Married _____ Never been Married _____ Divorced _____ Widowed _____

Years of School Completed _____ Can you read & write Y_____ N _____

Are you a Veteran Y ____ N ____ Veteran's Family Member Y ____ N ____ Relationship to Veteran _____

Previous Occupations _____

Do you have any chronic illness, disability, or health problems that may interfere with you becoming a Foster Grandparent? Y ____ N ____ If yes please explain _____

_____

Do you have experience with children, and with the handicapped? Y ____ N ____ If yes please explain _____

_____

Where did you first hear about the Foster Grandparent Program? _____

What makes you feel that you would be a successful Foster Grandparent? _____

_____

Do you have a car? Y ____ N ____ If yes could you transport other grandparents? Y ____ N ____

Please list your hobbies and special skills you have. _____

Are you active in any clubs or organizations? Y ____ N ____ If so please list them. _____

_____

Are you available to volunteer Mornings _____ Afternoons _____ Evenings _____ Hours _____

Dear Volunteer

When you accept a position as a volunteer with the Foster Grandparent Program at the City of Charles City, no matter where you are assigned, you assume as obligation to keep in confidence all information which pertains to the children and sites we serve. Remember that many of the duties you perform will involve the private lives of these children, and things that may happen in the class room. NO CONFIDENTIAL INFORMATION should be revealed or discussed with anyone not entitled to receive it. Even revealing the last name of your assigned children is considered a breach of confidentiality. Indiscriminate use of confidential information is not acceptable for anyone involved with providing services to the children and could result in disciplinary action (written reprimand, suspension, or termination).

Signature _____ Date _____

REFERENCES

1. Name _____ Address _____

City _____ State _____ Zip _____ Relationship _____

Phone # _____ Cell Phone _____

2. Name _____ Address _____

City _____ State _____ Zip _____ Relationship _____

Phone # _____ Cell Phone _____

I hereby certify that the above information is true and correct. Signed _____

(No Family Members Please) Date _____

Permission to do background check and finger prints

- A nationwide name-based check of the National Sex Offender Public Website (through True Screen)
- A name-based search of the Iowa Criminal History Check and a name or fingerprint-based search of the statewide criminal history registry in the candidate's state of residence if the candidate's place of residence is not Iowa.
- A Fingerprint-through Field Print.

I hereby give my permission to have background check and finger printing done.

Signature _____ Date _____

AUTHORIZATION TO TAKE AND USE PHOTOGRAPHS

I, the undersigned, hereby voluntarily grant to the AmeriCorps and the City of Charles City, without compensation, permission to take and use photographs of myself, with or without assigned children, and to use my name on radio, TV, or other media, for the purpose of illustration the Foster Grandparent Program of the City of Charles City.

Signature _____ Date _____

School Year: 2024 - 2025

AmeriCorps Seniors
Foster Grandparent Program
PO Box 63
705 3rd Avenue
Charles City, IA 50616
641-257-6327

VOLUNTEER ENROLLMENT FORM

Please Print and Complete all Sections

Last Name _____ First Name _____ Sex M_____ F_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Language Spoken _____

E-Mail Address _____

Ethnic Group (voluntary, for statistical reporting only) Caucasian ____ Asian ____ Hispanic _____

Native American _____ African American _____ Other _____

STIPEND BENEFICIARY

Name _____ Relationship to the volunteer _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Cell _____

EMERGENCY CONTACTS:

1. Name _____ Relationship to the volunteer _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Cell Phone _____

2. Name _____ Relationship to volunteer _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Cell Phone _____

PHYSICIANS NAMES

	NAME	ADDRESS	PHONE #
1.	_____	_____	_____
2.	_____	_____	_____

◯ Received a copy of car Insurance ◯ Received a copy of Drivers License

Signature _____

Date _____

School Year 2024 - 2025

ANNUAL INCOME REVIEW FORM FOR SERVING AMERICORPS SENIORS FOSTER GRANDPARENTS

In order to receive a stipend an AmeriCorps Seniors Foster Grandparent must be at least 55 years of age and cannot have an annual income from all sources, after deducting allowable medical expenses, which exceeds the program's income eligibility guideline for the state in which he or she resides. Annual income is required to be counted for the past 12 months for serving volunteers and is projected for the next 12 months for new applicants

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

Address: _____ **City**_____ **State** _____ **Zip Code**_____

No. in household _____ **Marital Status** ◯ **Married** ◯ **Single** ◯ **Divorced** ◯ **Separated** ◯ **Widowed**

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 Income Income (A&B)**		**D. Total Annual Income (C x 12)**
Social Security	$	$	$	x 12 mo.	$
SSI / SSDI	$	$	$	x 12mo.	$
Pension	$	$	$	x 12mo.	$
Interest /Dividends	$	$	$	x 12mo.	$
Other Income	$	$	$	x 12mo.	$
COLUMN TOTALS	$	$	$	x 12mo.	$

Allowable deductions for medical expenses, if any. Please note up to 50% of the maximized qualifying amount can be deducted. Other allowable deductions are listed on the back of this sheet.

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
	$	**Monthly Total**		$	**Yearly Total**

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 an AmeriCorps Seniors Foster Grandparent. I understand that a knowing and willful statement on this form can be punished by a fine or imprisonment or both under the Section 18, U.S.C.

VOLUNTEER SIGNATURE **DATE** **REVIEWED BY DIRECTOR** **DATE**

What is considered income for determining volunteer eligibility?

According to Section 2551.44 of the Foster Grandparent Program Regulations:

(a) For determining eligibility, "income" refers to total cash or in-kind receipts before taxes from all sources including:

(1) Money, wages, and salaries before any deduction;
(2) Receipts from self-employment or from a farm or business after deductions for business or farm expenses;
(3) 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 401(k) or other retirement savings plans;
(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 of 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) Regular payments for public assistance, including Supplemental Nutrition Assistance Program (SNAP);
(4) Social Security Disability or any type of disability payment;
(5) Food or rent received in lieu of wages.

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

According to the Foster Grandparent Regulations, 2551.43 (c):

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 pay or, and ***which do not exceed 50 percent of the applicable income guideline.***

Examples of allowable out-of-pocket medical expenses:

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

Prescription Drugs:
Pharmacy program co-payments and deductibles

Medical Bills for Dr. Visits:
Included, but not limited to: medical care, dental care, vision care not covered by health insurance

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 not covered by health insurance (pain relievers, antacids, hearing aid batteries, vitamins, non-prescription eye glasses)