Department of Human Services
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APPLICATION

Interested in: (Check box that applies please)

❑ **SENIOR COMPANION PROGRAM** ❑ **FOSTER GRANDPARENT PROGRAM**

(PLEASE PRINT)

1. NAME: ______________________ DATE: ______________
2. ADDRESS: ______________________ CITY: __________ ZIP CODE: ________
3. TELEPHONE: ______________ SEX: _____ DATE OF BIRTH: ____________ AGE: _____
4. SOCIAL SECURITY NO: ______________ MEDICARE NO. __________ MEDICAL NO. __________
5. MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED
6. IF MARRIED, GIVE NAME OF SPOUSE: ______________________
7. ETHNICITY:

❑ African American (AA)	❑ Asian Indian (AS)	❑ Guamanian (GU)	❑ Laotian (LA)
❑ Black American (BA)	❑ Cambodian (CA)	❑ Hawaiian (HA)	❑ Samoan (SA)
❑ American Indian (AI)	❑ Chinese (CH)	❑ Japanese (JA)	❑ Vietnamese (V)
❑ Hispanic (H)	❑ Filipino (FI)	❑ Korean (KO)	❑ Asian Other (AO)
❑ White (W)	❑ Other		

8. NUMBER OF CHILDREN: ________ GRANDCHILDREN: ________ GREAT-GRANDCHILDREN: ________
9. **EMERGENCY CONTACT NAME:** ______________________ **RELATIONSHIP:** __________

   ADDRESS: ______________________ **PHONE:** ______________
10. LIST ANY HOBBIES, SPECIAL SKILLS OR INTEREST YOU HAVE: ______________________
11. LIST ANY CLUBS OR ORGANIZATIONS OF WHICH YOU ARE A MEMBER: ______________________
12. HAVE YOU EVER DONE VOLUNTEER SERVICE? ______________________

    IF YES. WHAT DID YOU DO: ______________________
13. TYPE OF WORK YOU ENJOY DOING: ______________________
14. FORMER OCCUPATION: ______________________
15. DO YOU READ AND WRITE ENGLISH? ______________________
16. WHAT LANGUAGES DO YOU SPEAK? ______________________

17. ARE YOU A LICENSED DRIVER? ______ DO YOU OWN A CAR? ______ DRIVER LICENSE # ________________

18. YOUR PRESENT **MONTHLY** INCOME IS:

SOURCE		**AMOUNT**	**SPOUSE**
SOCIAL SECURITY		______	______
S.S.I. (GOLD CHECK)		______	______
PENSION		______	______
OTHER	______	______	______
	TOTAL:	$ ______	$ ______

19. THERE ARE __________ PERSONS IN MY HOUSEHOLD DEPENDENT ON THIS INCOME.

20. WHERE DID YOU FIRST HEAR ABOUT THE SENIOR COMPANION PROGRAM? ________________

21. DO YOU HAVE ANY CHRONIC ILLNESS OR DISABILITY? ________________

IF SO, EXPLAIN BRIEFLY: ________________

22. LIST ANY MEDICATION YOU ARE REQUIRED TO TAKE: ________________

24. NAME AND ADDRESS OF YOUR PHYSICIAN:

NAME: ________________ TELEPHONE: ________________

ADDRESS: ________________ ZIP: ________________

25. PLEASE LIST TWO REFERENCES (NOT RELATIVES) WHO KNOW ABOUT YOU AND YOUR ABILITY TO WORK WITH OTHERS:

NAME: ________________ TELEPHONE: ________________

NAME: ________________ TELEPHONE: ________________

26. LIST WORK OR VOLUNTEER EXPERIENCE WITH CHILDREN, YOUTH OR TEENS: ________________

DO NOT WRITE IN BOX (SCP/FGP ONLY)

- ❑ TB TEST ________________
- ❑ FINGER PRINT REVIEW ________________
- ❑ INTERVIEW RATE ________________