



Sponsored by the
Rotary Club of
Rock Valley Foundation, Inc.



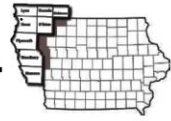
Foster Grandparent program



Senior Companion program



Rock Valley Office: 1510 14th Street Rock Valley, IA 51247 Phone: 712-476-2628
Sioux City Office: 4200 War Eagle Drive Sioux City, IA 51109 Phone: 712-224-2610
Website: www.rvrseniorvolunteerprograms.org



Serving Lyon, Osceola, Dickinson,
Sioux, O'Brien, Plymouth,
Woodbury & Monona Counties
& Dakota County, NE

Full Legal Name (First, Middle, Last): *Copy of photo I.D. must accompany application.			Date:		
Maiden Name, Other Legal Name previously used, and/or "Known As" Names:			Home Phone Number:		
Street/Mailing Address:		City, State, Zip		Cell Phone Number:	
Email Address (if applicable):		Birth Date:	Age:	Birth Place:	
Social Security Number:	Church Affiliations/Member:		Local Newspaper:		
<input type="checkbox"/> Married: spouse's name _____ <input type="checkbox"/> Single <input type="checkbox"/> Widowed			<input type="checkbox"/> Veteran Which Branch _____ <input type="checkbox"/> Family of a Veteran <input type="checkbox"/> Actively Serving <input type="checkbox"/> Have a Family member currently serving (who/which Branch) _____		
Previous Occupation:	Years of school completed:		Number of persons living in your household:		
Special Interests, Skills, Hobbies:			Type of transportation you use:		
Membership in Senior Clubs or organizations:			Language(s) spoken:		
Which program are you interested in? (circle choice)		Why are you interested in volunteering?			
Foster Grandparent / Senior Companion					

Emergency Contact Information

Name of Contact Person:		Phone:
Address (include City/State/Zip):		Relationship:
Name of Physician:		Phone:
Address (include City/State/Zip):		Hospital of Choice:

Physical Condition

Excellent: _____	Good: _____	Fair: _____	Poor: _____	{Please explain}

Yearly Income Sources and Amounts

In order to receive a stipend, a volunteer 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. See application attachment for definitions for income and allowable medical expenses.

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 months	\$
SSI / SSDI	\$	\$	\$	X 12 months	\$
Pension	\$	\$	\$	X 12 months	\$
Interest/Dividends	\$	\$	\$	X 12 months	\$
Other Income:	\$	\$	\$	X 12 months	\$
Other Income:	\$	\$	\$	X 12 months	\$
COLUMN TOTALS	\$	\$	\$	X 12 months	\$

Allowable deductions for medical expenses, if any. Please note up to 50% of the maximized qualifying amount can be deducted.

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:	\$ _____

List Three Personal References (Not Relatives)

Name and Address, City:	Phone Number:	Relationship:
Name and Address, City:	Phone Number:	Relationship:
Name and Address, City:	Phone Number:	Relationship:

Disclosure Statement

Have you ever received a deferred judgment or been convicted of a crime or misdemeanor (other than parking violations and juvenile offenses)? Please circle one: YES NO

Have you ever received a deferred judgment or been convicted of a felony? Please circle one: YES NO

If yes to either the above questions, please explain: _____

Have you even been charged with neglect, abuse or assault or had a protection order issued against you?

Please circle one: YES NO If yes, please explain: _____

Auto/Driver Information

Foster Grandparent and Senior Companion Programs do reimburse volunteers for their mileage. In order to qualify, please answer the following questions.

1. Will you regularly drive to your volunteer site or in-service? Please circle one: YES NO
2. Will you occasionally drive to your volunteer site or in-service? Please circle one: YES NO
3. Will you claim mileage for reimbursement from the Foster Grandparent or Senior Companion Programs? Please circle one: YES NO

In order for us to pay mileage reimbursement we need to have the following information. If we do not have this information, we are **not** allowed to pay out any mileage.

Name as it appears on your Driver's License: _____

Driver's License #: _____ State: _____ Expiration Date: _____

For our records, please submit a **copy of your photo I.D.** and **proof of auto insurance** with your application.

Beneficiary Information

In the event of my death, I instruct the Rock Valley Foster Grandparent /Senior Companion Programs to send my check to:

Name: _____

Address: _____

Relationship to Volunteer: _____

Volunteer Agreement

Photo Release

I authorize the RVR Foster Grandparent and Senior Companion Programs to photograph me and give them the absolute right and unrestricted permission to copyright, publish and/or use such photographs; in whole or part of, or composite for use in RVRFGP/SCP publications or websites. I waive any right that I may have to inspect and approve the finished product or the advertising copy that may be used in connection with, or the use to which it may be applied. I release, discharge and agree to hold harmless RVRFGP/SCP from any liability by virtue of any use whatsoever, whether intentional or otherwise, that may occur or be produced in the taking of said picture, or in any processing tending toward the completion of the finished product.

_____ Date: _____
Applicant's Signature

Confidentiality

As a Foster Grandparent or Senior Companion, I realize that I have an obligation to keep in confidence all information about the individuals I serve. I realize that NO CONFIDENTIAL INFORMATION is to be revealed or discussed with anyone (other than site staff or program staff); even telling the names of children or clients is considered a breach of confidentiality. I understand that revealing confidential information is not acceptable and could result in disciplinary action (written reprimand, suspension or termination).

_____ Date: _____
Applicant's Signature

Read carefully before signing:

I hereby consent to permit Rotary Club of Rock Valley Foundation (RVR) Foster Grandparent and Senior Companion Programs to contact anyone it deems appropriate to investigate or verify any information provided by me to discuss my suitability for a volunteer position, including my background, volunteer experience, education or related matters. I expressly give my consent to any discussions regarding the foregoing and I, voluntarily and knowingly, waive all rights to bring an action for defamation, invasion of privacy, or similar cause of action, against anyone providing such information.

I hereby give permission for RVR Foster Grandparent and Senior Companion Programs to conduct a State of Service and/or State of Residence criminal history record check with the Division of Criminal Investigation (DCI), an Iowa child, independent adult, and sexual offender abuse registries with the Dept. of Human Services, a National Sex Offender Public Website (NSOPW) check, and a FBI Background check. Any information maintained may be released as allowed by law. I understand participation in the RVR Foster Grandparent or Senior Companion Programs is contingent upon eligibility determined by criminal history and abuse registries review, acceptance, and the completed volunteer screening process.

I certify that the answers given by me to all questions on this application and any attachments are, to the best of my knowledge and belief, true and correct, and that I have not knowingly withheld any pertinent facts or circumstances. I understand that any omission or misrepresentation of fact in this application, is considered making a false statement, which may result in refusal of or separation from volunteer service upon discovery thereof.

Upon completion of criminal history record checks, I understand that I have the right to review a copy of the criminal history records at the RVR Foster Grandparent and Senior Companion Program Rock Valley office with qualified staff. I further understand that I have the right to challenge the accuracy and completeness of any information contained in any such reports and to obtain a determination as to the validity of such challenge prior to the final determination.

Service Agreement Statement

I, the undersigned, hereby state that if accepted as a Foster Grandparent or Senior Companion, I agree to the following:

- 1) Abide by the service policies and procedures of the program and that of its volunteer stations;
- 2) Communicate regularly with program and volunteer station staff;
- 3) Attend required pre-service orientation and training, monthly in-service trainings and participate regularly in program-related activities and functions.
- 4) Commit to serve a minimum average of 15 hours per week, if eligible for stipend reimbursement.

Signature:	Date:
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Personal Information about volunteers contained on this enrollment form, such as home addresses, social security numbers, etc., may be disclosed **ONLY** with the **expressed prior authorization** of the volunteer.

Please submit to nearest location:

Foster Grandparent & Senior Companion Programs

Sponsored by The Rotary Club of Rock Valley Foundation, Inc.

Rock Valley Office:
 1510 14th Street
 Rock Valley, IA 51247
 Phone: (712) 476-2628
 Fax: (712) 451-6889

Sioux City Office:
 4200 War Eagle Drive
 Sioux City, IA 51109
 Phone: 712-224-2610
 Fax: 712-577-7848

Website: www.rvrseniorvolunteerprograms.org

OFFICE USE ONLY: Signature FGP/SCP Staff Reviewer		Date:
Volunteer Eligible: YES _____ NO _____	Stipended _____ Non- Stipended _____	
Photo ID Attached: YES _____ NO _____	Volunteer Start Date:	



Waiver Agreement and Statement

For Criminal History Record Checks under the National Child Protection Act of 1993 (NCPA), as amended by the Volunteers for Children Act (VCA)

Pursuant to the National Child Protection Act of 1993 (NCPA), as amended by the Volunteers for Children Act (VCA), this form must be completed and signed by every current or prospective employee, volunteer, and contractor/vendor, for whom criminal history records are requested by a qualified entity under these laws.

I hereby authorize (*Name of Qualified Entity*) **Rotary Club of Rock Valley Foundation, Inc. (RCRVF)**

to submit a set of my fingerprints and this form to the Iowa Department of Public Safety (DPS), Division of Criminal Investigation (DCI) for the purpose of accessing and reviewing Iowa and national criminal history records that may pertain to me. By signing this Waiver Agreement, it is my intent to authorize the dissemination of any Iowa and/or national criminal history record that may pertain to me to the qualified entity with which I am or am seeking to be employed or to serve as a volunteer, pursuant to the NCPA/VCA.

I understand that, until the criminal history record check is completed, the qualified entity may choose to deny me unsupervised access to children, elderly or individuals with disabilities. I further understand that, upon request, the qualified entity will provide me a copy of the criminal history record check, if any, received on me and that I am entitled to challenge the accuracy and completeness of any information contained in such report. I may obtain a prompt determination as to the validity of my challenge before a final decision is made about my status as an employee, volunteer, contractor or subcontractor.

I **have** OR **have not** been convicted of a crime.

If convicted, describe the crime(s) and the particulars of the conviction(s) in the space below:

I am a current or prospective (check one): Employee Volunteer Contractor/Vendor

Signature: _____ Date: _____

Printed Name: _____

TO BE COMPLETED BY QUALIFIED ENTITY:

Entity Name: Rotary Club of Rock Valley Foundation, Inc.

Address: 1510 14th Street, Rock Valley, IA 51247

Telephone: 712-476-2628 Fax: 712-451-6889

Entity Assigned OCA: RCRVF



Foster Grandparent and Senior Companion Program

Income Eligibility Guidelines

Application Attachment



What is considered income for determining volunteer eligibility?

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, but not including food or rent in lieu of wages;
- (2) Receipts from self-employment or from a farm or business after deductions for business or farm expenses;
- (3) Regular payments for public assistance, Social Security, Unemployment or Workers Compensation, 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
- (5) Income from dividends, interest, net rents, royalties, or income from estates and trusts.

For eligibility purposes, income does not refer to the following money receipts:

- (1) Any assets not regularly 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) Food Stamps.

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

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.

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

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 (pain relievers, antacids, hearing aid batteries, vitamins, non-prescription eye glasses)