FOR OFFICE USE ONLY
Enrollment date: _____
NSOPW completed: _____
NC CHC:Initiated: _____
Completion date: _____
FBI FP Completed:_____
Closure date: _____

SENIOR COMPANION PROGRAM

Land of Sky Regional Council
339 New Leicester Hwy., Suite 140 • Asheville, NC 28806

VOLUNTEER APPLICATION

NAME: _____ PHONE: _____
First Middle Last

ADDRESS: _____
Street/PO Box City State Zip

E-MAIL:_____ AGE: _____ DATE OF BIRTH: _____

Education (highest year of school completed): _____ Marital Status: _____

How would you describe your physical condition? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Please explain: _____

With which ethnic group do you identify most strongly? ☐ African American ☐ Caucasian/Non-Latino
☐ Native American ☐ Latino ☐ Multi-Racial ☐ Asian/Pacific Islander ☐ Other _____

In case of an emergency, who should we contact?
Name: _____ Phone: _____
Personal Doctor's Name: _____ Phone: _____

Willing to serve (check all that apply): ☐ Mornings ☐ Afternoons
☐ Transportation ☐ Companionship ☐ Light Housekeeping ☐ Light Meal Preparation ☐ Respite

What is your main means of transportation? ☐ Car ☐ Bus ☐ Other_____

Please tell us about yourself.
Previous Occupation _____
Hobbies/Special Interests _____
Group Memberships_____
Are you a veteran? ☐ Yes ☐ No If Yes, dates of military service? _____

Tell why you wish to be a Senior Companion:_____
_____

What goals are you seeking in your volunteer work as a Senior Companion? (Check all that apply)
☐ Desire to help others ☐ For a sense of purpose ☐ Need extra income ☐ Stay Busy
☐ Desire for self-improvement ☐ Desire to be with others ☐ Give back to others ☐ Other

See next page →

Please list <u>two</u> character references not related to you (This is a grant requirement):

	Name	**Address**	**City/State/Zip**	**Phone**
1.				
2.				

If qualifying to receive a stipend; PLEASE LIST INCOME SOURCES AND AMOUNTS FOR CURRENT YEAR:

SOCIAL SECURITY $_____
SSI $_____
PENSION/RETIREMENT $_____
INTEREST $_____
STOCKS/BONDS $_____
OTHER (EXPLAIN) $_____
_____
Monthly TOTAL $_____

TOTAL NUMBER OF PERSONS IN HOUSEHOLD _____

OUT OF POCKET MEDICAL EXPENSES PER MONTH: $_____

ESTIMATED INCOME FOR NEXT 12 MONTHS $_____

In connection with the National Service Criminal History Check (NSCHC) requirements, all applicants must complete this disclosure form by answering the questions listed below. ***Please Note:*** *A "Yes" answer to any of the following questions* ***DOES NOT*** *automatically disqualify you for consideration.*
If you answer "Yes" to any question below, please explain, including dates, on a separate sheet of paper and attach to this application.

Have you ever been convicted of a crime? ☐ Yes ☐ No

1. Involving a violent act or threat of force against another person? ☐ Yes ☐ No
2. That was sexual in nature? ☐ Yes ☐ No
3. Where drugs, narcotics, or alcohol were involved? ☐ Yes ☐ No
4. Involving dishonesty, deception or fraud? (e.g. Worthless checks; food stamp fraud, etc.) ☐ Yes ☐ No
5. Within the last 7 years? ☐ Yes ☐ No

Acknowledgment and Permission to Conduct Record Check
I declare that all of the preceding information is true and correct to the best of my knowledge. I understand that any false or misleading information given by me can disqualify me from consideration, or will result in dismissal from the program. I hereby give permission for the SCP to conduct NCCHC, National Sex Offender Registry and FBI Fingerprint check of my criminal records to determine my suitability for program. Any volunteer accepted into the program has an on-going duty to report to the supervisor of any future criminal charges after being accepted into the program.

_____ _____
Applicant Signature Date

Please return this completed form along with a copy of your current driver's license or State ID to our office