HENRY STREET SETTLEMENT

Senior Companion Program

AmeriCorps Seniors

Dear Prospective Senior Companion Volunteer,

Thank you for your interest in becoming a Senior Companion Volunteer! Volunteers visit frail or homebound clients on a regular, weekly basis. Providing social support and companionship. To be a volunteer with SCP you must:

- **Be at least 55 years old**
- **Complete a federal background check (covered by program) and interview with SCP staff prior to training**
- **As of 10/1/21, proof of COVID vaccination is required**
- **Complete Two-Day Volunteer Orientation Training at SCP Office**
- **Commit to Five Hours of Service Each Week- Weekdays 9-5**
- **Volunteers must attend one monthly in-service training, offered in-person and virtually**
- **If eligible, volunteers are qualified for a tax- free stipend of $4.00/hour**

Please complete the enclosed application and return it to:

Senior Companion Program

265 Henry Street

New York, NY, 10002

Note: You must submit proof of income for the current year so we can determine if you qualify for our tax-free stipend (social security, SSI, pension award letters). You also will need to complete the medical clearance form with your doctor. It is required that all volunteers take a TB test before starting with the program.

If you are waiting for your doctor's appointment or proof of income, send in the rest of your completed application and turn in your medical clearance and proof of income when completed. Once you are invited to your interview, please bring the remainder of your documents on the first day.

If you have any questions, call 1-212-473-1474 extension 1345. You will be contacted when training dates have been determined and be scheduled for an interview with SCP Staff.

HENRY STREET SETTLEMENT
Senior Companion Program
AmeriCorps Seniors

VOLUNTEER APPLICATION 2025

Name: _____ **Nickname/preferred name**_____

Address: _____ **Apt:** _____

City: _____ **Borough:**_____ **Zip:** _____

Telephone: ( )_____ **Cell Phone: ( )**_____

E-Mail_____

Date of Birth: ____/____/_____ **Age:** _____ **Ethnicity:** ☐ **Hispanic** ☐ **Non- Hispanic**

Gender: ☐**Male** ☐**Female** ☐ **Gender fluid/ Does not identify** ☐ **Does not wish to disclose**

Racial status: ☐ **Asian** ☐ **African Am.** ☐ **White** ☐ **Native Am./Pacific islander** ☐ **Multiracial**

Marital Status: ☐**Married** ☐**Single** ☐**Widow(er)** ☐**Divorced**

Sexuality: ☐ **identify's as a member of the LGBTQ community**
☐ **Does <u>not</u> identify's as a member of the LGBTQ community** ☐ **unknown**

Veteran Status (Check all that applies): ☐ **I am a veteran** ☐ **My family member is a veteran**
☐ **My family member is in Active duty** ☐ **Not Applicable**

Do you identify as a member of the disability community/group? ☐ **YES** ☐ **NO**

Emergency Contact:

Name: _____ **Relationship:** _____

Address: _____ **Telephone:** _____

Borough: _____ **City:** _____ **Zip:**_____

Please list languages in which you are proficient:
Spoken: ☐**English** ☐**Spanish** ☐**Chinese: Dialect**_____
Read: ☐**English** ☐**Spanish** ☐**Chinese: Dialect**_____
Write: ☐**English** ☐**Spanish** ☐**Chinese: Dialect**_____

Travel:

- **How many blocks can you walk comfortably? ☐1-3 blocks ☐5 blocks ☐10 blocks ☐1 mile**
- **Which forms of public transportation do you use?: ☐Bus ☐Train ☐ Access-a-Ride**
- **How many flights of stairs can you climb?: ☐1-2 ☐3-5**
- **How much time are you willing to spend traveling to visit clients?: ☐15 minutes ☐30 minutes ☐45 minutes ☐ Other _____**

Health Information:

Physician/Clinic Attending: _____

Address: _____ Telephone: _____

Borough: _____ City: _____ Zip:_____

How did you hear about the Senior Companion Program?

☐Friend ☐Senior Companion Who?_____

☐Senior Center ☐N.O.R.C Which one? _____

☐Other _____

Please list any Hobbies & Special Skills you may have:

☐Reading ☐Crochet/Knitting ☐ Dancing ☐Fishing ☐Photography ☐Musical Instruments

☐Beadwork/Jewelry Making ☐Sewing ☐Scrapbooking ☐Bingo ☐Exercise/Walking

☐Traveling ☐Art ☐Volunteering ☐Cooking ☐Crafts ☐Other_____

Have you ever been a home health aide? ☐Yes ☐ No

If no, what kind of work have you done? _____
_____

What is the highest level of education you completed? _____
Have you ever been incarcerated? ☐No ☐ Yes If yes, when? what charges _____
_____

Please list two (2) character References (*not relatives*)

	Name	Address	City, State, Zip	Telephone
1.				
2.				

Please make sure you write the information above clearly and double check all phone numbers. If you need more room, write information below.

Please note, as per the federal Americorps Seniors Program, all potential volunteers must complete a fingerprint background check prior to training.

Income Eligibility Form

☐ **This is a new applicant**

In order to receive a stipend a Senior Companion 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. YOU MUST INCLUDE PROOF OF INCOME WHEN SUBMITTING THIS FORM (E.G.—SOCIAL SECURITY AWARD LETTER)

Name: _____ Phone: (_____) _____- _____ Birth Date: ___/___/___

Address: _____
Street City State Zip
Number in household: _____

Marital Status: ☐Married ☐Widow(er) ☐Single ☐Divorced ☐Legally Separated

Housing: ☐ Rent Home ☐ Own Home ☐ Occupy without payment

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

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: = $ _____**
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 a Foster Grandparent or Senior Companion. ***I understand that a knowing and willful false statement on this form can be punished by a fine or imprisonment or both under Section 1001 of Title 18, U.S.C.*** **_____ _____ _____ _____** **VOLUNTEER SIGNATURE DATE REVIEWED BY SCP DIRECTOR DATE**

PLEASE PROVIDE PROOF OF INCOME WHEN SUBMITTING APPLICATION

Proof of income is your social security or SSI award letter, pension letter, etc.

You are not eligible for stipend without this proof!

ENROLLMENT RECORD INSURANCE FORM

This form will be used to enroll you in the Accident and Liability Insurance policy which only covers you during your time in the field.

Emergency Contact

Name: _____ **Telephone:** _____

Address: _____
(Street) (City) (State) (Zip)

Emergency Contact

Name: _____ **Telephone:** _____

Address: _____
(Street) (City) (State) (Zip)

Beneficiary(s) for SCP Accidental Death Insurance

1. **Name:** _____**Relationship:**_____

Address: _____
(Street) (City) (State) (Zip)

2. **Name:** _____**Relationship:**_____

Address: _____
(Street) (City) (State) (Zip)

Signature of SCP Volunteer _____

Date _____

BACKGROUND CHECK DISCLOSURE NOTICE - AUTHORIZATION FORM

The following information is required for identification purposes when checking records. It is confidential and will not be used for any other purpose.

Name: _____ _____ _____
(Last Name) (First Name) (Middle Name)

Other name(s) used in any and all other records of birth or records of residences: _____

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number _____-_____-_____
(MM/DD/YYYY)

Gender: _____ Race: _____

Driver's License #: _____ State Issued: _____

In connection with my application for employment, my continues employment, or in connection with my desire to engage in volunteer activities, I have been advised and I hereby consent and authorize Henry Street Settlement, at any time during my application process and/or employment, to obtain an investigative consumer report that may include, but not be limited to, a criminal record check, sexual abuse registry check, employment and education verifications, verifications of personal references and reputation; and driving record. I do hereby consent and authorize Henry Street Settlement to use any information provided on this form or during the application process in obtaining the investigative consumer report. Upon request I have the right to review and challenge any negative information that would adversely impact me or adversely affect a decision to offer employment. I agree to release, indemnify and hold harmless Henry Street Settlement and any consumer reporting agency used by Henry Street Settlement with regard to any information reported by the consumer reporting agency. I acknowledge that facsimile, copy, or email of this document shall have the same validity, force and effect as the original.

1) I HEREBY CERTIFY THAT ALL INFORMATION PROVIDED IN THIS BACKGROUND CHECK DISCLOSURE NOTICE AND AUTHORIZATION FORM IS TRUE, CORRECT AND COMPLETE. I UNDERSTAND THAT INCORRECT OR INCOMPLETE INFORMATION MAY BE GROUNDS FOR TERMINATION OF CURRENT EMPLOYMENT OR CANCELLATION OF ANY AND ALL OFFERS OF EMPLOYMENT AT THE DISCRETION OF THE APPLICABLE AGENCY.

2) I UNDERSTAND APPLICANTS ARE REQUIRED TO REPORT ARRESTS MADE BETWEEN THE APPLICATION FOR EMPLOYMENT AND DECISION TO HIRE THE APPLICANT FOR EMPLOYMENT.

3) Notice to New York Applicants: Under Article 25 Sec 380-g of the NY General Business Law, should a consumer report received by an employer contain criminal conviction information, the employer must provide to the applicant or employee who is the subject of the report, a printed or electronic copy of Article 23-A of the New York Correction Law, which governs the employment of persons previously convicted of one or more criminal offenses.

Employee Signature: _____ Date: _____

Senior Companion Program
Funded by the Corporation for National and Community Services
265 Henry Street
New York, NY 10002

Ph: 212-473-1474
www.henrystreet.org

SENIOR COMPANION PROGRAM VOLUNTEER MEDICAL CLEARANCE

Your **patient** _____ wants to participate in the Henry Street Settlement Senior Companion Program. He/She will be working with homebound clients as a friendly companion in our Senior Companion Program. Volunteer duties will involve the ability to ride on public transportation, escorting clients to appointments, walking around the neighborhood, doing light food shopping and other light physical duties. Please complete this form to ensure that your patient can safely serve as a volunteer and attend necessary training without causing harm to oneself or clients.

Date of Assessment:_____/_____/_____

PATIENT'S NAME: _____ Date of Birth: ___/___/___

☐ NKDA ☐ Allergies: _____

Vital Signs: HT: _____ Wt: _____ BP: _____ R: _____ P:_____

PPD Implant: _____/_____/_____ ☐ LFA ☐ RFA

PPD Reading: _____/_____/_____ Results: ☐ NEG ☐ POS _____ x _____mm of induration

HX of Positive PPD CXR:_____/_____/_____ _____ LTBI Tx: _____ x _____mos

List any significant **medical, surgical, or mental health conditions**—including hospitalizations. Use additional pages if necessary. **[ ] None**

_____

List all ongoing treatments/medications that would impact service. **[ ] None**

_____

List any pertinent physical exam findings**. [ ] Within Normal Limits [ ] Abnormal findings listed:**

_____

Based on your evaluation, the Volunteer is:

[ ] Able to participate with no restrictions

[ ] Not able to participate in the program do to: _____

[ ] Able to participate with the following restrictions:_____

_____ _____

Physician Signature **Date**

OFFICIAL BUSINESS STAMP OF PHYSICIANS OFFICE: