Rhode Island Department of Human Services
Office of Healthy Aging
LP Building
57 Howard Avenue
Cranston, RI 02920

OFFICE OF HEALTHY AGING SCP ENROLLMENT FORM

Please print and complete all sections. Forms with original signatures are required for enrollment.

Name_____**DOB**_____**SSN**_____
Age_____
Mailing Address_____**City**_____
Zip_____
Phone _____**Cell Phone** _____**Email**
_____

Have you ever been convicted of a **criminal offense or misdemeanor**? Yes___ No___ **If Yes**, please attach an explanation of charges, date of offense, and status of the charges on a separate sheet to be included with this application.

Driver's License #_____ State_____ Expiration Date_____
SCP provides a mileage reimbursement for travel between home and volunteer site to the volunteers.
Will you be claiming a mileage reimbursement for travel to and from your volunteer location?
Yes__ No__ If Yes, is a copy of your proof of auto insurance showing active coverage attached? Yes __ No__

As a SCP volunteer, you will be covered by accident and personal liability insurance plus a small death benefit while performing volunteer duties. This coverage is automatic and free of cost to you, as long as you are an active, enrolled member of SCP. Please provide the following information.

Emergency Contact_____**Phone**_____

The following information will help SCP match you with a volunteer opportunity:

Employment Experience_____
Special Skills/Interests/Languages_____
_____
Volunteer Experience (Current, Past) _____
_____
Days/Hours Available: Mon___ Tues___ Wed___ Thu___ Fri___
Mornings___ Afternoons___

Do you require any special accommodations or have physical or medical considerations that may impact a volunteer assignment?

_____

Please indicate if SCP may have permission to use your likeness?

[ ] I hereby grant The Division of Elderly Affairs/SCP permission to use my likeness in photograph(s)/video(s) in any and all of its publications or on the world wide web, whether now known or hereafter existing, controlled by SCP of Rhode Island in perpetuity. I will make no monetary or other claim against SCP of Rhode Island for the use of these photograph(s)/video(s).

[ ] I do not give permission to use my likeness in photograph(s)/video(s) to The Division of Elderly Affairs/SCP of Rhode island.

SCP is often asked to provide demographical information pertaining to volunteer members. Please provide the following information (Optional).

Are you a Veteran? _____ Are you an active Military Member? _____

Are any of your family members actively serving in the military?

_____

(Optional) Gender: (Optional) Race/Ethnic Background:

____Male ___White ___Asian ____African-American ____Hispanic/Latino

____Female ___American Indian/Alaska Native ___Pacific Islander ___Other

Thank you for the information you have provided. Your information is **never** sold, shared, or used outside of SCP, Division of Elderly Affairs or the Corporation for National and Community Service.

Income Review

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				
SSI / SSDI				
Pension				
Interest/Dividends				
COLUMN TOTALS				

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

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/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 STAFF** **DATE**