

INTERVIEW DATE: _____ CHC DATE SUBMITTED: _____

CHC REVIEWED: _____ PRE-SERVICE DATE: _____

SOUTHEAST TEXAS FOSTER GRANDPARENT PROGRAM

2210 EASTEX FREEWAY - BEAUMONT, TX 77703 - (409)899-8444

Please answer each question as thoroughly as possible. Please print or type your answers. If you have any questions regarding the Southeast Texas Foster Grandparent Program or need any help completing this form, please feel free to contact our office at (409) 899-8444, extension 6441 or 7510. Thank you

Name: _____
Last Name First Name Middle Name

Address: _____
Street City or Town State Zip Code

How long has you lived at this address? _____

If under one year, what was your previous address? _____

Telephone Number: _____ Cell Phone: _____

Social Security Number: _____ Date of Birth: ____/____/____

Email: _____ Age: _____

Birthplace: _____

Driver's License #: _____ State Issued: _____

Expiration Date: ____/____/____

PLEASE CHECK ONE BELOW: Married [☐] Widowed [☐] Single [☐] Divorced [☐]

SEX: Male [☐] Female [☐]

SETX FGP is often asked to provide demographic information about volunteer members. Please provide the following information.

RACE: Please check one box below:

African American or Black [] Asian [] European American or White []

Native American [] Native Hawaiian or Pacific Islander [] Other []

ETHNICITY: Please check one box below: Hispanic [] Non-Hispanic []

Years of school completed: _____ Previous Occupation: _____

Are you a veteran? _____ Which branch? _____

PHYSICAL CONDITION:

Please describe your physical condition:

Excellent [] Good [] Fair [] Poor []

Please explain if you consider your physical condition fair or poor: _____

List any medications you are currently using, the reason you are taking the medication, and the milligrams of the medication below: **PLEASE WRITE CLEARLY . USE ADDITIONAL PAPER, IF NEEDED.**

| MEDICATION NAME | PURPOSE OF MEDICATION | DOSAGE | AM | PM |
|-----------------|-----------------------|--------|----|----|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do you have any medication allergies? (If so, please list them below)

PHYSICIAN INFORMATION:

Physician's Name: _____

Address: _____ **Phone #:** _____

EMERGENCY CONTACTS:

#1: Name: _____

Address: _____
Street **City/State** **Zip Code**

Home Telephone Number: _____

Cell Phone Number: _____

Relationship: _____

#2: Name: _____

Address: _____
Street **City/State** **Zip Code**

Home Telephone Number: _____

Cell Phone Number: _____

Relationship: _____

HEALTH INSURANCE INFORMATION:

Medicare #: _____ Part A: ____ Part B: ____

Medicaid #: _____

Please list any other supplemental insurance policies you may have:

1. _____
2. _____
3. _____

TRANSPORTATION INFORMATION:

What kind of transportation do you plan to use?

Personal vehicle [☐] Public transportation [☐] Senior Transportation [☐]
Other [☐]

If you plan to use your personal automobile, do you have:

Current Liability Insurance: Yes [☐] No [☐] (Please provide a copy)

Vehicle Insurance Company: _____

Policy _____ #: _____

Insurance Expiration Date: ____/____/____

OTHER INFORMATION:

Please provide a list of memberships in senior clubs or organizations:

1. _____

| _____ | Name of Organization | Years |
|-------|----------------------|-------|
|-------|----------------------|-------|

| | | |
|----------|----------------------|-------|
| 2. _____ | Name of Organization | Years |
|----------|----------------------|-------|

HOBBIES:

Please list any hobbies, special training, and special skills you may have:

1. _____
2. _____
3. _____
4. _____

Please list any language (s) you can speak other than English:

1. _____
2. _____
3. _____

Explain why you wish to become a Foster Grandparent: _____

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

AVAILABILITY:

Days of the week: [] Mon [] Tues [] Wed [] Thurs [] Fri

Are you willing to volunteer at least 15 hours each week? ☐ Yes ☐ No

Are you willing to commit to volunteering at least for one year? ☐ Yes ☐ No

Have you ever volunteered or been employed in any capacity around children?

☐ Yes ☐ No If so, please explain: _____

Have you ever been arrested, charged, or convicted of a felony or misdemeanor?

☐ Yes ☐ NO If yes, please provide an explanation of the charges. _____

Did it result in imprisonment? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been convicted for a motor vehicle offense such as DWI or DUI?

☐ Yes ☐ No If yes, please explain: _____

Have you had any experience with adults and/or children with emotional and/or physical problems? ☐ Yes ☐ No If yes, please explain: _____

How were parented as child? _____

What form of discipline did your parents use? _____

Have you ever been exposed to child abuse or neglect, and/or physical, emotional, mental, or sexual abuse? [☐] Yes [☐] No **Explanation is optional:** _____

HOUSEHOLD INCOME INFORMATION:

How many people are in your household? _____ Provide their name and relationship to you:

| Name | Relationship |
|----------|--------------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |

Please list the monthly medical expenses for your household after insurance reimbursement. List your income under the column marked applicant, list the income of other person (s) living in your household under the column marked other.

| | APPLICANT | OTHER |
|-----------------------------------|-----------|----------|
| Monthly health insurance payments | | \$ _____ |
| \$ _____ | | |
| Monthly medications | | \$ _____ |
| \$ _____ | | |
| Monthly health care services | \$ _____ | \$ _____ |

Please list sources of your monthly income below for your household:

| | | |
|--|----------|----------|
| Social Security | \$ _____ | \$ _____ |
| State Supplemental Income (SSI) | \$ _____ | \$ _____ |
| Annuity Income | \$ _____ | \$ _____ |
| Pension Income | \$ _____ | \$ _____ |
| Income from Rental Property | \$ _____ | \$ _____ |
| Income from Stocks & Bonds | \$ _____ | \$ _____ |
| Public Assistance | \$ _____ | \$ _____ |
| Unemployment | \$ _____ | \$ _____ |
| Workers Compensation | \$ _____ | \$ _____ |
| Other Sources | \$ _____ | \$ _____ |

To the best of my knowledge, I certify that the information I have given is true and correct. I understand that misrepresentation or omission of facts is a sufficient reason for application disqualification and/or dismissal. My signature indicates agreement for investigation and inquiries to be conducted by the Foster Grandparent Program relative to the information I have supplied on this application, including but not limited, to a criminal history record, FBI fingerprint, a reference check, and investigation into my history. I waive any rights to confidentiality regarding the information in this application.

Applicant Signature

FOR OFFICE USE ONLY:

FGP Staff Signature

____/____/____
Date of Review

Any comments/observations: _____

REFERENCES:

Please list **3** character references who are **NOT RELATIVES**. Please indicate how long you have known each of these references. (Failure to list **complete addresses, including zip codes**, will hold up processing your application).

Reference #1:

Name: _____

Address: _____
Street City/State Zip Code

Home/Cell Number: _____ Years Known: _____

Relationship: _____

Reference #2:

Name: _____

Address: _____
Street City/State Zip Code

Home/Cell Number: _____ Years Known: _____

Relationship: _____

Reference #3:

Name: _____

Address: _____
Street City/State Zip Code

Home/Cell Number: _____ Years Known: _____
Relationship: _____

THIS SECTION FOR FGP STAFF USE ONLY

(PLEASE DO NOT WRITE IN THIS SECTION)

FOR OFFICE USE ONLY:

| | |
|--|--------------|
| Total Grandparent Monthly Income: | \$ _____ (+) |
| Total Monthly Income from Others: | \$ _____ (+) |
| Monthly Medical Deductions: | \$ _____ (-) |
| Total Household Income/Month: | \$ _____ |
| Total Household Income x 12 Months: | \$ _____ |
| Total Household Income Guidelines: | \$ _____ |
| Plus 20% (FGP over 1 year) (_____) in household | \$ _____ |
| TOTAL INCOME | \$ _____ |

**I CERTIFY THAT THE APPLICANT OR FOSTER GRANDPARENT
VOLUNTEER **IS / IS NOT** ELIGIBLE TO CONTINUE IN THE PROGRAM.**

**FGP PROJECT STAFF SIGNATURE
REVIEW**

_____/_____/_____
DATE OF