

**GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES
DEPARTMENT OF HUMAN SERVICES**

Application for Foster Grandparent Program

Instructions

- 1. You must be 60 years of age or over to apply.**
- 2. Please fill all spaces that apply to your situation. If you need assistance please feel free to ask the person who furnished the application.**
- 3. Print or type the information if possible.**
- 4. Please list any volunteer experiences in section for employment.**
- 5. Applicants will be interviewed by the Director of Foster Grandparent Program.**

FGP VOLUNTEER APPLICATION
(St. Thomas, USVI)

_____ (Name Typed or Printed)

_____ (Signature) _____
(Date)

Address: _____
(Street, City or Town, Zip Code)

Telephone No. Social Security No. Medicare No. Medicare No.

Age Birth Date Birth Place Married__ Single__ Widowed __

Years of School Completed _____ Previous Occupation _____

Physical Condition:

Excellent__ Good__ Poor__

Please Explain: _____

Name, address, and phone number
Of contact in Emergency _____

Name address, and phone
Number of Physician: _____

No. of Persons Living in your home: _____

Income Sources & Amounts

Name(s) of Legal Dependents: _____

Social Security \$ _____
SSI \$ _____
Amunity Income \$ _____

Your Estimated Net Income for the Next
12 Months \$ _____
Total Income for Your Entire

Pension Income \$ _____
Net Rest Income \$ _____
Interest Income \$ _____

Household:

Income from Stocks & Bonds \$ _____

Current _____

Public Assistance \$ _____

Next 12 Months _____

Other \$ _____

Total \$ _____

Tell why you wish to be a Foster Grandparent: _____

What kind of transportation do you plan to use? _____

Membership in Senior Clubs or Organizations: _____

Hobbies and Special Skills: _____

Language(s) spoken: _____

Willing to Serve: Mornings _____ **Afternoons** _____

Two Character References (Not Relatives):

Name: _____ **Phone #** _____

Address: _____

Name: _____ **Phone #** _____

Address: _____

VOLUNTEER ENROLLMENT RECORD AND INSURANCE FORM

Miss.
Mrs.
Name Mr. _____
(Last) (First)

Address _____

State _____ Zip Code _____ Phone# _____

Birth Place _____ Language Spoken _____

Public School _____ High School _____

College _____

Single _____ Married _____ Widowed _____

Emergency Contact Name _____ Phone _____

Address _____ City _____ State _____

Station _____ Assignment _____

BENEFICIARY (S) FOR ACCIDENT INSURANCE

Name _____ Relationship _____

Address _____ City _____ State _____

Name _____ Relationship _____

Address _____ City _____ State _____

Signature Date