



SENIOR COMPANION PROGRAM VOLUNTEER APPLICATION

Mailing: PO Box 988
Physical: 1000 Mission Avenue, Kenai, AK 99611
Phone (907) 335-7280 Fax (877) 290-1809

Preference shall be given to eligible qualified Alaska Native and American Indian applicants pursuant to P.L. 93-638 Indian Self Determination Act

GENERAL INFORMATION

First Name	MI	Last Name			
Mailing Address	City	State	Zip	Contact Phone Number	Email Address
				Alternate	
Emergency Contact Name		Phone Number		Relationship	
				Alternate	
Preference: Kenaitze Tribal Member <input type="checkbox"/> Yes <input type="checkbox"/> No			Alaska Native/American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you over 55 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Desired Volunteer Status:				Date Available:	
<input type="checkbox"/> 30hrs-40hrs <input type="checkbox"/> 15hrs-30hrs <input type="checkbox"/> On-Call				_____	
What times are willing to serve: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening					
What week day(s) are you willing to serve: <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun					
Do you have a current and valid Alaska driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you have a clean DMV record for the last 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain _____					

Do you have your own means of transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what kind of transportation do you plan to use?					

Do you have current proof of insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					

*****VOLUNTARY INFORMATION – FOR REPORTING PURPOSES*****

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
Ethnic Origin: <input type="checkbox"/> Alaska Native/American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Black (Non Hispanic) <input type="checkbox"/> White
Veteran Status: <input type="checkbox"/> Yes <input type="checkbox"/> No
Limitations/Impairments: <input type="checkbox"/> Physical <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Non-English Speaking <input type="checkbox"/> Developmental

REFERENCES *please provide us with two (2) professional references if possible*

Name	Job Title
Company	Phone Number
Name	Job Title
Company	Phone Number

HEALTH

Are you able to perform the essential duties of the volunteer position for which you have applied? Yes No

If no, explain _____

BACKGROUND INFORMATION if necessary use back of application

Have you ever been found guilty of, or entered a plea of no contest or guilty to, any felonious or misdemeanor offense, under federal, state, or tribal law involving

- Medicaid, Medicare, any state health care program, including any offense related to the delivery of an item or service under one of these programs?
- Crimes of violence, sexual assault, molestation, exploitation, contact, or prostitution, crimes against persons; or offenses committed against children?
- A controlled substance?
- Any other felonious or misdemeanor offense?

Yes No *If yes*, provide an explanation of the violation, place of occurrence, date and disposition of the court proceeding, and the name and address of the police department or court involved.

Have you ever been arrested or charged with a crime involving a child?

Yes No *If yes*, provide the date, explanation of the violation, disposition or the arrests or charge, place of occurrence, and the name and the address of the police department or court involved.

A criminal history record check is a condition of becoming a volunteer with Kenaitze Indian Tribe, and you are required to consent, including the submission of any necessary fingerprints and forms. Local, state, national, or other databases may be searched as part of the background check.

PLEASE READ CAREFULLY

I certify by my signature that the information I have given on this Volunteer Application is true and complete. I understand that my concealment or misrepresentation may be considered cause for termination of the volunteer relationship between myself the Kenaitze Indian Tribe.

I consent to employment and reference checks, drug and alcohol testing, and criminal history checks as may be requested by a KIT representative. I understand that if I do not pass the criminal history check the volunteer relationship between myself and Kenaitze Indian Tribe will be terminated.

I consent to annual physical examinations. I understand that if I do not pass the physical examination or cannot fulfill my volunteer duties without detriment to either myself or the adult(s) I'm serving I will be considered ineligible to continue my volunteer relationship between myself and Kenaitze Indian Tribe's Senior Companion Program and the volunteer relationship will be terminated.

Print Name

Signature

Date



VOLUNTEER QUESTIONNAIRE

What appeals to you most about being a volunteer with Kenaitze Indian Tribe's Senior Companion Program?

What skills, qualifications and hobbies do you have?

What do you hope to gain from your volunteer experience?

Are you willing to volunteer where someone smokes? **Yes** **No**

Are you willing to volunteer where someone owns animals? **Yes** **No**

Are you willing to commit a minimum of 15 hours a week on a regular basis? **Yes** **No**

Are you willing to drive on behalf of Kenaitze Indian Tribe, using your own personal vehicle? **Yes** **No**

Are you currently a volunteer for another program or agency? **Yes** **No**

Do you have any questions?

ELIGIBILITY FORM FOR SENIOR COMPANION APPLICANTS RECEIVING STIPENDS

1 Person	2 Person	3 Person	4 Person	5 Person	6 Person	7 Person	8 Person
\$29,440	\$39,840	\$50,240	\$60,640	\$71,040	\$81,440	\$91,840	\$102,240

HOUSEHOLD COMPOSITION **ALL HOUSEHOLD MEMBERS MUST BE REPORTED**

Full Name	DOB	Relationship to Applicant

INCOME WORKSHEET **ALL HOUSEHOLD INCOME MUST BE REPORTED**

Income Source	Yes/No	Who Receives?	Monthly	Annual	Verified
Wages or Salary	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Tip Income	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Interest/Dividends	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Alimony	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Child Support	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Self-Employment	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Stocks, Bonds, Real Estate	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Pensions, Annuities, and/or IRA	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Unemployment Compensation	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Workers Compensation	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Social Security Benefits	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Public Assistance Benefits	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Rental Property Income	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Alaska PFD	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Native Dividends	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>
Other Income	<input type="checkbox"/> Yes / <input type="checkbox"/> No				<input type="checkbox"/>

MEDICAL EXPENSES					Verified
Health Insurance Premiums	\$ _____	per month	or \$ _____	per year	<input type="checkbox"/>
Prescription Drugs	\$ _____	per month	or \$ _____	per year	<input type="checkbox"/>
Doctor visits/medical bills	\$ _____	per month	or \$ _____	per year	<input type="checkbox"/>
Other allowable medical costs	\$ _____	per month	or \$ _____	per year	<input type="checkbox"/>

PLEASE READ CAREFULLY

I certify that the information furnished above is correct and understand that falsification of information may result in my being deemed ineligible to serve as a Senior Companion. I understand that a knowing and willful false statement on this form can be punished by a fine or imprisonment or both. I understand that I must submit all supporting income verifications as requested by Kenaitze Indian Tribe's representatives. I understand that failure to submit required documentation will result in ineligibility to participate as a volunteer in the Senior Companion Program.

I understand that after I've been determined eligible for a stipend if my HOUSEHOLD income exceeds 20% of the maximum income guidelines based on 200% of the Federal poverty line I will immediately report the changes to my income to the authorized Kenaitze Indian Tribe representative. I understand that if I'm determined to be ineligible to receive a volunteer stipend the volunteer relationship between Kenaitze Indian Tribe and myself will be terminated.

Volunteer Signature

Date

Staff Signature

Date