

POTENTIAL VOLUNTEER PRESCREEN

DATE: _____

INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ ZIP: _____ COUNTY: _____ REGION/WARD: _____

CELL: _____ HOME: _____

EMAIL: _____

GENDER: _____ DOB: _____ AGE: _____

MARITAL STATUS: MARRIED _____ SINGLE: _____ DIVORCED: _____ WIDOWED: _____

ETHNICITY

HISPANIC OR LATINO _____ NON-HISPANIC OR NON-LATINO _____

MODE OF TRANSPORTATION

DRIVER _____ TX DL NO: _____ METRO/METRO LYFT _____ OTHER _____

RACIAL GROUP

NATIVE AMERICAN OR ALASKA NATIVE _____ ASIAN/ASIAN AMERICAN _____
AFRICAN AMERICAN/BLACK _____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER _____
WHITE/CAUCASIAN _____ TWO OR MORE RACES _____

HOUSING

HOME OWNED BY SOMEONE IN THE HOUSEHOLD WITH MORTGAGE _____
HOME OWNED BY SOMEONE IN THE HOUSEHOLD FREE/CLEAR OF MORTGAGE _____
RENT APARTMENT/HOME _____ LIVING WITH SOMEONE WITHOUT PAYMENT/RENT _____
(Please list name/relation)

TOTAL ANNUAL INCOME (Please list amount)

SOCIAL SECURITY BENEFITS _____ RETIREMENT _____ ALLOMONY _____ OTHER _____

\$24,999 or less _____ \$25,000 to \$39,999 _____ \$40,000 to \$59,999 _____ \$60,000 to \$74,999 _____
\$75,000 to \$99,999 _____ \$100,000 to \$149,999 _____ \$150,000 or more _____

MILITARY SERVICE INFORMATION

ARE YOU/SPOUSE A VETERAN _____ FAMILY MEMBERS WHO ARE ACTIVE-DUTY MILITARY _____

EMERGENCY INFORMATION (Please list 2)

EMERGENCY CONTACT NAME: _____ PHONE: _____

RELATIONSHIP: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

RELATIONSHIP: _____

HEALTH INFORMATION DO YOU HAVE DISABILITY? _____ PLEASE EXPLAIN: _____

ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL CONDITIONS

WHAT (IF ANY) SOCIAL/ PHYSICAL ACTIVITY OR HOBBIES DO YOU ENGAGE IN AND HOW OFTEN?

TELL US ABOUT YOURSELF

WHY DO YOU WANT TO BE AN AMERICORPS SENIOR COMPANION VOLUNTEER?

VOLUNTEER DUTIES

PLEASE CHECK WHICH DUTIES YOU ARE MOST COMFORTABLE PERFORMING

COMPANIONSHIP _____ PREPARE LIGHT MEALS _____ REMIND OF MEDICATION _____ ASSIST WALKING _____

ASSIST WITH ADL _____ PERSONAL GROOMING/DRESSING _____ TAKE TO GROCERY STORE _____

RESPIRE CARE FOR FAMILY _____ RESPIRE CARE FOR CAREGIVER _____ ALLOW FAMILY TO RUN ERRANDS _____

TAKE TO DR. APPOINTMENT _____ LIGHT HOUSEKEEPING _____ OTHER AS NEEDED _____

SCHEDULE

WHAT DAYS AND TIMES ARE YOU AVAILABLE TO SERVE

MONDAY _____ TUESDAY _____ WEDNESDAY _____ THURSDAY _____ FRIDAY _____

Please be advised that completing and signing this form does not imply that you have been selected to become an AmeriCorps Seniors Senior Companion Program Volunteer. This document is for interview/screening purposes only. After completion of the Federal background check/fingerprint, and volunteer training, we will make every effort to assign a suitable client. If you agree and understand, please sign below.

STAFF SIGNATURE: _____ **DATE:** _____

DIRECTOR SIGNATURE: _____ **DATE:** _____

OFFICE USE ONLY:

Date Received: _____ Call/Emailed: _____ Staff Initial: _____