



Community Action Foster Grandparent Enrollment Form

In order to ensure continuity and stability for our Community Action Head Start children, we ask our Foster Grandparents to commit to 20-35 hours per week.

In order to qualify for the program, annual income has to be at or below:

- \$25,760 for a family of one
- \$34,840 for a family of two
- \$43,920 for a family of three
- \$53,000 for a family of four

If you are close to any of these totals or have questions about determining your income, please contact Sam Bates at (402) 875-9320.

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

First Name _____ Last Name _____

Birth Date _____ Age _____

Mailing Address _____ City _____ Zip _____

Phone _____ Cell Phone _____

Email _____

Primary Language _____

How did you hear about us? _____

Foster Grandparent Program 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 ___

Driver's License # _____ State _____ Expiration Date _____

*Do you have a minimum coverage amount of \$100,000/\$300,000 auto liability insurance?

Yes ___ No ___

* If yes, do you have a copy of your active automobile policy?

Yes ___ No ___

As a Foster Grandparent volunteer, you will be covered by accident and personal liability insurance plus a small death benefit while performing your volunteer duties. This coverage is automatic and free of cost to you as long as you are an enrolled and active Foster Grandparent with Community Action.

Please provide the following information.

Beneficiary for FGP/SCP Supplemental Accident Insurance:

Name _____ Relationship _____

Address _____ Phone _____

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

Employment Experience _____

Special Skills or Interests:

Volunteer Experiences: (current or past)

Would you prefer an infant, toddler or a preschool room? _____
(Every effort will be made to place you in your preferred room)

Days/Hours Available: Mon___ Tues___ Wed___ Thu___ Fri___

Mornings Afternoons Time from __:__:__ to __:__:__

Total hours per week _____

Do you typically go on annual vacations or have any known times that you will request time off (Holidays with out of state family)? If so please list.

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

Equal Employment Agency – Community Action Partnership of Lancaster and Saunders Counties is an equal opportunity agency and does not discriminate in hiring on the basis of race, color, religious creed, national origin, sex, sexual orientation, gender identity, mental or physical disability, marital status, or age. No question on this enrollment form is intended to be used for such discrimination. We will provide reasonable accommodations to the known disabilities of applicants, unless doing so would pose an undue hardship. Please feel free to let us know if you need accommodation to complete the enrollment process. For accommodation information or if you need special accommodations to complete the enrollment process, please contact Community Action Partnership of Lancaster and Saunders Counties Foster Grandparent Program at (402) 875-9320.

Return completed enrollment to: Community Action FGP
210 O Street
Lincoln, NE 68508

Questions? Contact:
Sam Bates: (402) 875-9320
sbates@communityactionatwork.org

I understand that background information will be checked using TrueScreen and Fieldprint vendors and will be considered as a result of my application for the Foster Grandparent Program. This information may include but is not limited to the following:

- Central Registry for Adult and Child Abuse
- Criminal History
- Sex Offender Registry
- National registry check
- National Criminal History Check

I certify that all statements are true and complete to the best of my knowledge and I understand that to knowingly misrepresent and/or omit facts called for herein will be sufficient cause for cancellation of consideration for the Foster Grandparent Program or dismissal, if I am already enrolled in the program.

I authorize Community Action Partnership of Lancaster and Saunders Counties to investigate all information contained in the application. I have the right to make a written request within a reasonable period of time for complete and accurate disclosure of additional information concerning the nature and scope of this background check. In addition, my signature on this document will serve as authorization to release any and all information recorded on or attached to my application to Community Action Partnership of Lancaster and Saunders Counties. A photocopy or facsimile of this document is as valid as the original.

I understand that this application is not a contract of employment.

Signature _____ Date _____

Staff signature _____ Date _____

The following information is optional and will not affect your enrollment with Community Action Partnership of Lancaster and Saunders Counties Foster Grandparent Program.

Occasionally Community Action FGP will purchase volunteer recognition gifts for our Foster Grandparents. Please share your sizes below.

Item	Size
Jacket	_____
Sweatshirt	_____
Vest	_____
T-Shirt	_____

Which show of appreciation would mean the most to you? *(Check all that apply)*

- Special meals
- Small gift
- Certificate
- FGP logo shirt or jacket
- Interviewed for a news story
- Other _____
- Verbal thank you
- Written thank you

FGP is often asked to provide demographical information pertaining to volunteer members.

Please provide the following information:

Are you a Veteran? Yes ___ No___ **Are you an active Military Member?** Yes ___ No___

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

If yes, who? _____

Do you identify as a member of the LGBTQ community? Yes ___ No___

Do you identify as a member of the Disability community? Yes ___ No___

Gender:

____ Male
____ Female
____ Gender fluid/Do not identify as male or female

Racial Group:

____ Hispanic/Latinx
____ Non-Hispanic/Latinx

Racial/Ethnic Background (Please check all that apply):

____ Native Hawaiian or other Pacific Islander ____ Hispanic/Latinx ____ Native American or Alaska Native
____ White/Caucasian (Non-Hispanic) ____ African American/Black ____ Asian/Asian American

Thank you!

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