Foster Grandparent Program
2328 Fifth Avenue, 2nd Floor
Troy, NY 12180
518-272-6012 Ext.291

Dear Potential Foster Grandparent Volunteer,

The Foster Grandparent Program is a paid volunteer program that places older adults (age 55 and older) into youth programs to provide one on one mentoring and guidance to children from pre-school through early adulthood.

CEO's Foster Grandparent Program places volunteers at stations where children learn in a classroom setting. Volunteers assist with activities like tutoring, practical learning experiences, and many other hands-on activities. Volunteering offers the opportunity for older adults to share their many life experiences with younger generations.

The Foster Grandparent Program has great benefits! Foster Grandparent Volunteers will earn a tax-free stipend that *does not* interfere with any benefits they receive (Social Security, Subsidized Housing, Medicare/Medicaid). We offer paid time off, training, partial travel reimbursement, annual recognition events.

The Foster Grandparent Program is a federally funded program under AmeriCorps Seniors that requires volunteers to meet income eligibility in order to volunteer. The income for a single person for 2025 is $30,120 and married is $40,880 per year. The program also requires that volunteers commit to a minimum of 5 hours per week with a maximum of 40 hours. CEO operates the Foster Grandparent Program in 3 counties consisting of Albany, Rensselaer, and Schenectady.

Please complete and return the enclosed application and medical release forms to begin the enrollment process. If you have any questions or would like more information, please call **(800)455-6014 or our direct number: (518)272-6012 ext 291**

The Capital District Foster Grandparent Program

Hosted by The Commission on Economic Opportunity

Foster Grandparent Volunteer Application

Legal Name _____ Date of Birth ___/___/___ Age _____

Preferred Name _____ Phone _____

Address _____ Mailing, if different _____

Total Annual Income- Self: _____ Spouse: _____

T-Shirt Size: S M L XL 2XL Other (circle one)

Veteran: Yes No (circle one)

Any other immediate (within household) family members military- active or retired? Yes No (circle one) If so, how many? _____

Disabled: Yes No (circle one)

1. How were you referred to our program? Please provide person's name, if applicable.
   _____
2. What interests you in becoming a Foster Grandparent Volunteer?
   _____
3. Are you able to commit to serving a minimum of 15 hours per week? _____
4. Do you have a reliable source of transportation (personal or public)? _____
5. What children's age group are you most interested in working with? _____
6. What days/times are you available to volunteer?

Days:	Monday	Tuesday	Wednesday	Thursday	Friday
Times:					

Please list 2 personal references who are NOT related to the applicant.
Reference #1- Name _____ Phone Number _____

Reference #2- Name _____ Phone Number _____

I certify that the information furnished above is correct. I also agree to allow the Commission on Economic Opportunity to run and review the required clearances and background checks as part of the application process.

_____

Foster Grandparent Applicant Signature Date

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

CHILD DAY CARE PROGRAMS

INSTRUCTIONS:

- If the **only role is household member**, complete **only** the front page. If you are a **medical professional**, a signature is required on **both sides** of this form.
- **Only** a health care provider (physician, physician's assistant, nurse practitioner) may complete/sign the Medical status section.
- **A registered nurse is NOT authorized to sign the Medical Status section but CAN sign the TB Test Information on the reverse**.
- A health care professional may use an equivalent form as long as the information on this form is included.
- See additional instructions about the tuberculin test on the reverse side.
- Please **PRINT** clearly.

I attest that I have not forged or altered any information contained in this document. I am aware that the submission and/or possession of forged or altered documents may constitute a crime. In addition to potentially being subject to criminal prosecution, any program found to have submitted and/or possessed such documents may be subject to fines by the NYS Office of Children and Family Services, and/or denial or revocation of a license or registration.

Program name:	Facility ID number:
Person's name:	Date of birth:
Person's signature:	

TYPE OF PROGRAM:	**Family Day Care, Group Family Day Care and Small Day Care Centers**	**Day Care Center and School-Age Child Care**	**All Programs**
ROLE:	☐ Provider ☐ Substitute ☐ Assistant ☐ Household Member (GFDC/FDC)	☐ Director ☒ Volunteer ☐ Group Teacher ☐ Assistant Teacher	☐ Employee

Typical child day care duties

- Lifting and carrying children
- Close contact with children
- Direct supervision of children
- Driver of vehicle
- Food preparation
- Desk work
- Facility maintenance
- Evacuation of children in an emergency

Following to be completed by health care provider ONLY

Medical status

To the best of my knowledge of the above-named individual, I find that:			
He/She is currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care.	☐ YES	☐ NO	
He/She has a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.	☐ YES	☐ NO	
He/She has a physical condition that would prevent him/her from providing typical child day care duties as described above.	☐ YES	☐ NO	☐ NA *(if only role is volunteer or household member)*
For any "YES" responses, clarify and/or indicate restrictions:			

Signature *(physician, physician's assistant, nurse practitioner)*

Title

Name *(please PRINT clearly or use office stamp)*

/ /
Date of Exam

( ) -
Phone

/ /
Date of Signature

*(**Continued on reverse side**)*

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

CHILD DAY CARE PROGRAMS *(continued)*

Program name:	Facility ID number:
Person's name:	Date of birth:

INSTRUCTIONS:

- **Household members** in a family-based program that have no other role **do not need to have** a tuberculin test and do not need to complete this page.
- A health care professional (physician, physician's assistant, nurse practitioner) *and a registered nurse as part of his/her duties at a health care facility*, may enter the results in the tuberculin test Information section and sign this page.
- Acceptable tuberculin tests include Mantoux or other federally approved tuberculin test.
- Please **PRINT** clearly.

Following to be completed by health care professional ONLY

Tuberculin test information

Test completed

Test read on: ____/____/____
(mm / dd / yyyy)

Test result: ☐ Positive ☐ Negative _____ mm

If Positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety?
☐ Yes ☐ No

Test not completed

☐ Not tested. Provide reason: _____

_____
Medical exemption or contraindication

If test result was previously Positive, indicate ____/____/____
(mm / dd / yyyy)

If previously Positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety?
☐ Yes ☐ No

Signature *(physician, physician's assistant, nurse practitioner and registered nurse)*

Signature (registered nurse)

Name *(please PRINT clearly or use office stamp)*

Title

( ) -
Phone

____/____/____
Date

INSTRUCTIONS FOR PROGRAMS TO RETURN THE FORM:

- **GFDC/FDC programs:** return this completed form to your licensor or registrar.
- **DCC/SACC programs:** for directors-return this completed form to your licensor or registrar; for all other staff - return the form to the director for evaluation.