



When form is completed email to karen.kelly@nebraska.gov

SENIOR HELP PROGRAM ELECTRONIC VOLUNTEER APPLICATION

DATE: _____

FULL NAME: _____ Name used: _____ M F
(First, Middle, Last)

ADDRESS: _____ COUNTY: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS: _____

PHONE: (Home) _____ (Work) _____ (Cell) _____

DOB AND SS# ARE REQUIRED BY THE STATE OF NEBRASKA TO CONDUCT BACKGROUND CHECKS:

DATE OF BIRTH (DOB): _____

SOCIAL SECURITY NUMBER (SS #): _____

RACE (OPTIONAL for Demographic Purposes Only): White Black Hispanic Asian Indian

Other _____

PLEASE LIST TWO CHARACTER REFERENCES: (References must be at least 21 yrs old. No family members please) PLEASE PRINT CLEARLY AND INCLUDE ALL INFORMATION REQUESTED (Name, address, zip, phone and email) :

Name	Address	Zip	Phone
E-mail			

Name	Address	Zip	Phone
E-mail			

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: (Home) _____ (Work) _____ (Cell) _____

DOES SMOKE BOTHER YOU? Yes _____ No _____

OCCUPATION (Current or Previous): _____

EMPLOYER: _____ RETIRED: Yes _____ No _____

SCHOOL (Currently): _____

What is your major or field of study? _____

LIVE: Alone _____ With spouse _____ With family _____ Other _____

WHAT KIND OF TRANSPORTATION DO YOU USE? (May check more than one)

Car _____ Truck _____ SUV _____ Bus _____ Taxi _____ Other _____

FOR DRIVERS: Drivers license # _____ State issued _____

INSURANCE CO: _____ AGENT: _____

WHAT TYPE OF WORK HAVE YOU DONE IN YOUR LIFE? _____

HAVE YOU EVER VOLUNTEERED BEFORE? Yes _____ No _____ IF SO, WITH WHOM?

Name of Organization	Length of Time as Volunteer

WHAT DID YOU LIKE BEST ABOUT YOUR OTHER VOLUNTEER EXPERIENCES? _____

WHAT DID YOU LIKE LEAST? _____

DO YOU SPEAK ANY FOREIGN LANGUAGES? (Including sign language) Yes _____ No _____

What language(s)? _____

WHAT ARE YOU SPECIAL SKILLS, INTERESTS OR HOBBIES?		
SPECIFIC SKILLS	INTERESTS	HOBBIES

HOW DID YOU FIND OUT ABOUT SENIOR HELP? _____

WHY DO YOU WANT TO VOLUNTEER WITH US? _____

ARE YOU COMFORTABLE WORKING WITH DIVERSE POPULATIONS? Yes _____ No _____

If no, please explain: _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? Yes _____ No _____

If yes, please explain: _____

HAVE YOU EVER BEEN REPORTED TO ADULT PROTECTIVE SERVICES (APS)?

Yes _____ No _____ If yes, please explain: _____

IF ENROLLED, YOU WILL RECEIVE A MONTHLY MAILING. WOULD YOU PREFER TO RECEIVE BY:

E-mail _____ Regular Mail _____

Criminal Background Checks will be conducted on all applicants for volunteer placements through the SeniorHelp Volunteer Program.

I authorize the Eastern Nebraska Office on Aging (ENOA) to conduct a criminal background check and hereby release and discharge, to the extent permitted by law, the Eastern Nebraska Office on Aging, its employees, and any individual or agency obtaining information for ENOA for any and all claims known or unknown, damages, losses, liabilities, cost, or other expenses arising from the retrieving, reporting, and/or disclosure of information in connection with this investigation. I certify to the best of my knowledge and belief that the information provided by me is correct and complete. I understand that any false information contained on this document will disqualify me from service with the Eastern Nebraska Office on Aging SeniorHelp Volunteer Program.

SIGNATURE OF APPLICANT

DATE

PROGRAM COORDINATOR SIGNATURE

DATE



CONFIDENTIALITY AGREEMENT

I, _____, hereby agree to honor the rights of confidentiality of the clients I serve through the SeniorHelp Volunteer Program of the Eastern Nebraska Office on Aging (ENOA). I agree that the well-being of the clients served is of the greatest importance. I respect the right to confidentiality and will safeguard confidential information as required by ENOA and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for every person served. Violations of confidentiality and/or the HIPAA regulations will result in termination from the SeniorHelp Program.

This means I will respect the client's rights by not repeating anything they may tell me: I will not disclose any personal, medical or demographic information, including names, addresses and phone numbers to *anyone*, including (mine or the client's) family, friends, neighbors, co-workers church members, clergy, and media. Exceptions include the SeniorHelp Volunteer Program staff and to other enrolled volunteers for projects and assignments *strictly* on a *need-to-know* basis only.

I fully understand that violation of the rights of the clients served and breaking confidentiality will be cause for my termination from the SeniorHelp Volunteer Program.

VOLUNTEER SIGNATURE _____

DATE _____

PROGRAM DIRECTOR _____

DATE _____



Eastern Nebraska Office on Aging
4223 Center Street
Omaha NE 68105
444-6536

WHAT IS HIPAA?

DOES IT IMPACT YOU AS A VOLUNTEER?

It is essential that you understand the requirement to keep information about our clients confidential. We will only share information with you that we feel is relevant to your task, but we know our clients will often share more information as you develop relationships with them. There can be civil and criminal consequences for not complying with the HIPAA privacy law therefore it is important to understand how it interfaces with agency volunteers and your responsibility to protect confidentiality as an Eastern Nebraska Office on Aging (ENOA) SeniorHelp Volunteer.

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. HIPAA is a public law, a set of federal regulations relating to the transfer of and security for **protected health information (PHI)**. The *Protected Health Information* referred to in the HIPAA privacy law includes any information related to a person's past, present or future **physical** or **mental** health. PHI also includes any information that could identify a person, (living or deceased).

This law applies to you as an agency volunteer because of your direct access to our clients through the ENOA SeniorHelp Volunteer Program and potentially to their *health information* because of that access. SeniorHelp volunteers have agreed to provide services to clients as agency volunteers and therefore have an obligation to maintain client privacy.

Signing the enclosed confidentiality form provides the Eastern Nebraska Office on Aging satisfactory assurance that as an agency volunteer you will appropriately safeguard the client information shared with you in any form - spoken, written or electronic. This means you are not to share any information pertaining to a client's medical condition or health information without permission from the SeniorHelp Volunteer Program staff. Names, addresses, phone numbers, or any other identifying information about our clients should not be shared with **anyone** other than SeniorHelp staff or other specifically designated agency staff or persons.

The HIPAA law requires this accountability to preserve and respect the privacy of the clients we serve. Failure to comply with the confidentiality agreement will result in termination from the SeniorHelp Volunteer Program.

VOLUNTEER SIGNATURE _____
(I have read and understand this explanation and agreed to comply with these instructions)

PLEASE PRINT NAME _____

DATE _____

PROGRAM COORDINATOR _____

DATE _____



WAIVER

I, _____ am enrolled as a volunteer in the SeniorHelp Volunteer Program of the Eastern Nebraska Office on Aging (ENOA). As a volunteer, I will be providing services to older adults.

As a volunteer in this program, I waive all claims or causes of action, which may arise in connection with services I provide or tasks I perform. This waiver includes claims, which may be asserted against other ENOA program participants and the Eastern Nebraska Office on Aging for services provided or tasks performed under the auspices of this volunteer program.

This waiver is valid until expressly revoked in writing by the volunteer.

Signature of program participant

Date

Print name of participant



Eastern Nebraska Office on Aging

EASTERN NEBRASKA OFFICE ON AGING

SENIORHELP PROGRAM

TRANSPORTATION VOLUNTEER AGREEMENT

I, _____, a participant in the SeniorHelp Volunteer Program sponsored by Eastern Nebraska Office on Aging, agree to use my personal automobile in my performance as a transportation volunteer. I certify that I am a licensed driver in the State of Nebraska and currently have the required automobile liability insurance in effect and understand that I must keep in effect automobile liability insurance equal to the minimum limits required by the State of Nebraska. Proof of insurance may be requested at any time by the SeniorHelp Volunteer Program staff.

NEBRASKA DRIVERS LICENSE NO. _____

EXPIRATION DATE _____

NAME OF INSURANCE CARRIER _____

Signed by: _____

Date: _____



Eastern Nebraska Office on Aging

VOLUNTEER OPPORTUNITIES

*I am willing to help with:
(please check all interests)*

- Companion/Personal Visitor (Nursing Home, Hospital, Residence)
- Escort/Transportation (Local)
- Holiday Gift Delivery (done in December)
- Home Maintenance/Handy man (Please list specific skills inside application)
- Household/Personal Assistance
- Interpretation (Spoken or Sign language)
- Lawn Mowing
- Moving Assistance
- One-time Clean-ups
- Painting
- SeniorHelp/ENOA Office Assistance
- Snow Removal
- Student/Service Learning Project
Name of School _____
- Telephone Reassurance (Make daily call to check on individual at risk)
- Telephone Visitor
- Yard Care
- Meals on Wheels Delivery (meals are delivered M-F between 10:30 & 1:00)

Volunteer's signature _____ **Date** _____

Comments: _____



Eastern Nebraska Office on Aging