ALL CARE HOSPICE

VOLUNTEER APPLICATION

Volunteer Information

First Name:* _____ Last Name:* _____ Date:* _____

Phone:* _____ Email:* _____

Address:*_____

City:* _____ State:*_____ Zip Code:*_____

DOB:* _____Social Security Number:* _____

How long have you lived at this address listed above? _____ (Years) _____ (Months)

Emergency Contact

Name: _____ Phone: _____

Volunteer Bio Information

Name of Volunteer:_____Date: _____

The following are ideas/suggestions to include. Please share what you are comfortable with.

Family information (significant other/spouse, children, pets)

Hobbies

How long have you lived in Arizona or other states/countries you have lived in

Career Path (where you started, why you chose your field, why it's important to you)

What draws you to be a volunteer?

Favorite Snack/Treat/Drink

Shirt/Jacket Size ☐S ☐M ☐L ☐XL ☐XXL

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Questions

Have you ever been convicted of a crime? ☐Yes ☐No
If yes, please explain:

What type of volunteering are you interested in? Some examples may include direct patient contact, clerical, pet therapy, music therapy, veteran support, crafts, etc.

How did you hear about All Care Hospice?

Do you have a current CPR Certification? ☐Yes ☐No

Do you current hold any verifications or licenses? ☐Yes ☐No
If yes, what

Have you ever had a TB test? ☐Yes ☐No
If yes, what was the most recent date and result:

Are you a current college student? ☐Yes ☐No
If yes, please note the name of school/major

Are you employed? ☐Yes ☐No
If yes, please list the name of employer:

Are you a veteran? ☐Yes ☐No
If yes, which branch?

Did you service active duty? ☐Yes ☐No

Are you interested in being part of our We Honor Veterans events? ☐Yes ☐No

Please share past or current volunteer experience

What do you hope to gain from this volunteer experience?

What is your availability?

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Do you have access to transportation? ☐Yes ☐No

What geographical areas are you willing to travel to?

What are your skills and/or special interests?

Do you have any limitations/conflicts that may interfere with volunteering? ☐Yes ☐No
If yes, please explain.

Do you have any pet allergies and/or hesitations about volunteering in homes with pets? ☐Yes ☐No

What languages do you speak?

What are your thoughts and feelings on death and the dying process.

Have you ever been a caregiver and/or family member involved with someone using hospice services?
☐Yes ☐No

If yes, please share your experience, if you are comfortable doing so.

Is there anything else you would like us to know about you?

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Volunteer Health Evaluation

Name of Volunteer:_____Date: _____

Allergies

Do you have any allergies? (check all that apply)

☐Latex or vinyl ☐Chemicals/household products ☐Soaps/personal care products

☐Foods ☐Pollen/dust ☐Certain types of clothing/gloves

☐Other allergies:

Communicable Diseases, Vaccinations or Antibody Titers

Check the box that describes the communicable disease, vaccinations or antibody titers you have had. Please include the date(s) of vaccination or titer completion.

Disease	Had the Disease?		Had the Vaccine?		
Rubeola (Red Measles - 7 Day)	☐Yes	☐No	☐Yes	☐No	Date _____
Rubella (General Measles – 7 Day)	☐Yes	☐No	☐Yes	☐No	Date _____
Mumps	☐Yes	☐No	☐Yes	☐No	Date _____
Chicken Pox	☐Yes	☐No	☐Yes	☐No	Date _____
Tetanus/Diphtheria	☐Yes	☐No	☐Yes	☐No	Date _____
Polio	☐Yes	☐No	☐Yes	☐No	Date _____
Pneumococcal	☐Yes	☐No	☐Yes	☐No	Date _____
Influenza (Flu)	☐Yes	☐No	☐Yes	☐No	Date _____
Tuberculosis	☐Yes	☐No	☐Yes	☐No	Date _____

Please Note

If you are pregnant or planning pregnancy, please discuss the occupational risks peculiar to your position (such as exposure to communicable disease, exposure to cleaner/disinfectant fumes, lifting) with your physician. If you have any condition that may prevent you performing assigned duties satisfactorily, these must be discussed with your employer. All information will be kept confidential.

Signature

By signing the below, I certify that the information on this health evaluation is complete and accurate to the best of my knowledge, I hereby certify that I am free of any physical, mental or emotional condition that would be detrimental to the well being of those in my care.

Volunteer Signature:_____Date: _____

Parent/Guardian Signature: _____Date: _____

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Volunteer

Position Description and Responsibilities

Volunteers are considered home care and hospice employees, performing roles under the supervision of the designated home care and hospice staff. There are multiple positions of volunteers whom perform specific responsibilities; these positions are outlines in essential functions below.

Reports to Volunteer Coordinator

Qualifications

- Education, preparation, and/or experience to include:
- High school graduate, or holds and equivalent certificate
- Emotional maturity and stability, and good communication and listening skills
- Sensitivity to the needs of patient/family in stressful situations
- Ability to accept different lifestyles, cultures, beliefs, and values
- Ability to work as a team member
- Desire to be of service to others
- Experience with human service work, preferred for patient care volunteers
- Some office experience is preferred for administrative volunteers

To become a volunteer, the following must be completed:

- Volunteer paperwork
- Criminal background check
- Current CPR card
- A negative Two-Step TB skin screening

Functions

Patient Care Volunteer

- Provides respite care and companionships to the patients under the supervision of the case manager.
- Confers with the referring staff prior to a first visit for orientation, and consults with the staff as necessary thereafter.
- Activities are based on an assessment and plan developed by the IDG.
- Visiting and offering companionship, emotional; support, and friendship
- Reading, writing letters, playing games
- Staying with the patient to allow family/caregiver to run errands
- Telephone reassurance

Bereavement Volunteer

- Provides ongoing emotional support to families or significant others of deceased hospice patients, as needed, for up to 18 months after the death of a patient
- Personal visits
- Condolence letters
- Telephone follow-up

Administrative volunteer

- Performs a variety of office/administrative tasks
- Assists with data entry and statistical report generation
- Plans and coordinates special functions
- Undertakes special projects
- General activities

All Volunteers complete and submit to the office, documents on activities and hours of service. Volunteers record patient services on the appropriate homecare and hospice forms.

Volunteers are required to update and submit the required documents needed to keep their volunteer file up to date. Volunteers are also required to complete 90-day Evaluations and Annual Evaluations to assess their volunteer service.

By signing this form, I have read and understand the above volunteer description.

Volunteer Signature:_____Date: _____

Parent/Guardian Signature: _____Date: _____

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Volunteer Preferences and Limitations

Name of Volunteer:_____Date: _____

Basic Information

Do you have any physical limitations ☐Yes ☐No
If yes, please explain:

Do you travel frequently? ☐Yes ☐No
If yes, do you have a trip planned for longer than 3 weeks? ☐Yes ☐No
What days/hours of the week are best for you? ☐Mon ☐Tue ☐Wed ☐Thu ☐Fri ☐Sat ☐Sun
Are there any times that you are not available? ☐Yes ☐No
Please list times you are unavailable

Preferences and Limitations

Please be as honest as possible in order to pair you with the best potential match.

Are you wiling to work with the same family for several months? ☐Yes ☐No
Are you willing to fill in on a short notice? ☐Yes ☐No
Do you have any allergies (ex: smoke, mold, animals)? ☐Yes ☐No
If yes please explain

How many miles away from your home are you willing to travel?
Are there living conditions you are uncomfortable with (ex: no plumbing or electricity, multiple animals, large groups of people, children, smoking)? ☐Yes ☐No
If yes, please explain

Would you be interested in completing activities with children or teenagers of patients? ☐Yes ☐No
Do you prefer to volunteer for: ☐Women ☐Men ☐Either
Are there certain ages or illnesses you want to avoid, perhaps due to personal experience? ☐Yes ☐No
If yes, please explain

Are you comfortable helping patients transfer to/from their bed, wheelchair, into the bathroom, etc?
☐Yes ☐No
Are you comfortable working with patients who have a history of drug or alcohol abuse? ☐Yes ☐No
Are you comfortable working with patients who may be very near death? ☐Yes ☐No
Would you be interested in making bereavement calls and/or visits? ☐Yes ☐No
Is there anything else you would like to share? Please share below

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Volunteer Interest Form

Name of Volunteer:_____Date: _____

Please check areas of skill and/or interest:

☐ Baking	☐ Handyman/Fix-it Projects	☐ Bereavement
☐ Interpreter/Translation	☐ Clerical/Computer	☐ Painting/Drawing
☐ Respite Care	☐ Sewing/Crocheting	☐ Event Planning
☐ Pet Therapy	☐ Gardening/Landscaping	☐ Religious/Spiritual
☐ Teaching	☐ Beautician/Barber	☐ Reading
☐ Light Chores/Housekeeping	☐ Music Therapy	☐ Play and Instrument
☐ Crafting	☐ Playing Games	☐ Singing
☐ Sports	☐ Watching TV/Movies	☐ Writing (letters, journal, etc.)
☐ Floral Arrangements	☐ Meal Preparation	☐ Photography

Other Notes

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Volunteer Orientation And File Checklist

Name of Volunteer:_____Date: _____

Documents And Forms

- ☐ Volunteer Application
- ☐ Interview/Reference Form
- ☐ Job Description
- ☐ Employee Health Evaluation
- ☐ Interest Form
- ☐ Tb Test (2 Step PPD)
- ☐ Driver's License
- ☐ Hepatitis B Vaccine Statement with Declination
- ☐ Car Registration
- ☐ Drug/Alcohol Screen Form
- ☐ Car Insurance
- ☐ HIPAA Agreement
- ☐ CPR/First Aid Card
- ☐ Equipment Checkout Form
- ☐ Volunteer Handbook Policy
- ☐ Competency Evaluation
- ☐ Background Check

Orientation And Training

- ☐ Classroom Training Course
- ☐ HIPAA Training
- ☐ OSHA Training (Blood Borne Pathogens, TB, Infection Control)
- ☐ Training Evaluation
- ☐ Documentation Training
- ☐ First Initial Visit with Patient and Volunteer Coordinator

Once all tasks are completed, please sign and return to the Volunteer Coordinator to verify completion.

Volunteer Signature:_____Date: _____

Parent/Guardian Signature: _____Date: _____

Volunteer Coordinator Signature: _____ Date:_____

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Gifts, Donations, Flowers, And Funerals

- You cannot accept payment for services or gifts of appreciation.
- Please do not purchase any out-of-pocket gifts, items, or other goods; if you find that something is needed for a patient or family, reach out to the Volunteer Coordinator.
- If invited to attend, volunteers are allowed and encouraged, but not required to attend funerals, celebrations of life, or other services honoring patients they have worked with.
- If a patient or family member or caregiver would like to make a monetary donation, they can mail the donation to:

Volunteer Commitment And Confidentiality Agreement

I agree to serve as a Hospice Volunteer with All Care Hospice. I understand the act of volunteering means a commitment to our hospice program. You will be promising to do specific work, and your agreement to do this without compensation will not change the face that our staff and patients will be depending on you.

1. I affirm that I have read and agree to and abide by the above statement.
2. I have read the Volunteer Job Description and I can complete all requirements and uphold the expectations set forth in the responsibilities.
3. I understand that an interview and volunteer training is required by every applicant.
4. I understand that I will have to obtain a criminal background screening and a TB skin test, at no cost through All Care Hospice. I am also required to obtain a CPR certification at my own costs within 30 days of my volunteer start date.
5. I understand that I am required by Medicare to submit a copy of my driver's license, car registration and car insurance. If these expire during my volunteer time, I will provide the office with an updated and current copy.
6. I understand that as an All Care Hospice volunteer, I must show compassion, respect, and professionalism to all team members, patients and families and caregivers.
7. I must provide advance notice of resignation or change to inactive status, as well as participate in an exit interview.
8. I certify that the statements made on the application are true and correct to the best of my knowledge. I understand that by submitting this application I authorize inquiries to be made concerning my character, volunteer service, and public records for the purpose of determining my suitability as a volunteer.

Volunteer Signature:_____Date: _____

Parent/Guardian Signature: _____Date: _____

PRINT FORM SUBMIT FORM