Community Care Team

Hospice Family Care

Volunteer Service Application

We are honored that you consider Hospice Family Care a place worthy of your time and talents!

Note: Upon completion of this application, the attached signature forms, and two (2) references, the Volunteer Coordinator will contact you to schedule an interview. Please return all materials to Hospice Family Care.
Email: volunteercoordinator@hospicefamilycare.org.
Prefer Electronic Forms? Submit electronically at www.hospicefamilycare.org, under the Volunteers tab.

Name: _____ DOB: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

Email: _____ *(Email is used frequently in this program)*

BACKGROUND

Volunteers are not required to have professional experience in end of life care. We provide training. However, you do have unique experiences, skills, and talents that can enrich our program. Tell us about yourself.

_____

_____

_____

Religious / Spiritual Affiliation (optional): _____

Social Club / Organization Affiliation (optional): _____

Foreign languages spoken: _____

Have you experienced the loss of a loved one within the last 12 months? Yes or No. *If yes, who?* _____

SERVICE PREFERENCES

Do you have access to personally insured transportation? Y or N Miles willing to travel from home? _____

Area of interest (circle all that apply):

Note: *For patient / family contact, volunteers must be at least 16 years old and have access to personally insured transportation. Parental consent is required for applicant's under 18 years old.*

Patient/Family Home Visits **Inpatient Facility** **Vigil Support** **Child Grief Support** **Administrative**

Adult Grief Support **Outreach / Education** **Special Events** **Sponsorship Coordination**

How did you hear about the Community Care Team / Volunteer Program at Hospice Family Care? _____

Volunteers with direct patient/family contact must complete a background check, drug screening, and TB Test? If asked, are you willing to complete these? Yes or No

_____ _____

Volunteer Applicant's Signature Date

3304 Westmill Drive, Huntsville, AL 35805 | office (256) 650-1212 | fax (256) 880-2929
volunteercoordinator@hospicefamilycare.org

Hospice Family Care

Hospice Family Care Inc.

Confidentiality Statement

As an employee, student, volunteer, or individual acting in any capacity in connection with Hospice Family Care, Inc., I agree to the following:

1. All charts, notes and other written material concerning patient/family that contains patient names will be retuned to be filed and/or locked for security reasons when not in use.
2. Discussions regarding patients/families will be held only staff offices or other places that assure privacy and only with authorized HFC personnel.
3. No privileged information about patients/families will be discussed with their family and/or friends.
4. For privileged information, written or verbal to be shared with other agencies and professionals written authorization must first be obtained from the patient or his/her legal representative.
5. Access to medical is limited to employees of HFC and graduate students (interns) who are supervised by staff and whose job description requires access to medical records. Access to medical records by anyone else must be approved the President of Hospice Family Care.

I recognize that any violation of the above that causes unauthorized disclosure of confidential patient/family or employee information is cause for immediate termination without entitlement to any notice or pay in lieu of notice.

_____ _____ _____

Print Name Sign Name Date

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Hospice Family Care

DISCLOSURE AND AUTHORIZATION

TO RELEASE INFORMATION

I understand that in connection with my application for employment/volunteer, a report may be requested. This report may contain information as to my character, general reputation and personal characteristics.

I hereby authorize and request any former employers, school, law enforcement agency, or other persons having personal knowledge about me to furnish a background check if requested and all information in their possession regarding me, in connection with an application for employment.

I understand and offer my consent to inquire into and/or obtain any records as previous employment, reference, educational, motor vehicle records, workers compensation and criminal histories.

I acknowledge that a photocopy or fax of this authorization be accepted with the same authority as the original. According to the FCRA, I am entitled to know if employment/volunteering is denied because of the information obtained from the Consumer Reporting Agency, If so, I will be notified and given the name and address of the agency or the source, which provided the information.

I understand that my consent will apply throughout my employment, to the extent permitted by law. I have read and understand this disclosure and consent form.

_____	_____	_____
Print Name	Sign Name	Date

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Community Care Team

Hospice Family Care

Volunteer Reference Form

Prefer submitting an electronic form? You can complete this form online at www.hospicefamilycare.org, under the Volunteers tab.

I. Volunteer Applicant completes the following information:

I, _____, authorize _____
Volunteer applicant name *Name of person giving reference*

to give a personal reference of myself to Hospice Family Care.

II. Person giving the reference completes the following information:

Name: _____ Telephone: _____

1) How long have you known the above person? _____
2) In what capacity have you known him/her? _____

_____

3) What is your sense of his/her coping skills if working with dying patients? _____

_____

_____

_____

4) Other comments: _____

_____

_____

_____

_____ _____
Signature of Person Giving Reference Date

Please return to:
Hospice Family Care
Volunteer Services Dept
3304 Westmill Drive
Huntsville, AL 35805

Email: volunteercoordinator@hospicefamilycare.org

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III. Volunteer Applicant completes the following information:

I, _____, authorize _____
Volunteer applicant name *Name of person giving reference*

to give a personal reference of myself to Hospice Family Care.

IV. Person giving the reference completes the following information:

Name: _____ Telephone: _____

5) How long have you known the above person? _____

6) In what capacity have you known him/her? _____

_____

7) What is your sense of his/her coping skills if working with dying patients? _____

_____

_____

_____

8) Other comments: _____

_____

_____

_____

_____ _____
Signature of Person Giving Reference Date

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