HOSPICE OF HOPE, INC.

Volunteer Application

Thank you for your interest in becoming a Hospice of Hope volunteer. The following information will provide us with a clear understanding of your abilities and interests and will help us to best channel your energies and capabilities. This information has proven most helpful in making volunteer assignments.

GENERAL INFORMATION

Name: _____
Last First Middle
Address: _____

_____

Telephone: Home: _____ Cell: _____ Work: _____

Email: _____

Employer:_____ Occupation: _____

Briefly describe type of work you do: _____

_____

_____

Hours you normally work: _____ May we contact you at work? ❑ Yes ❑ No

Check times you would be interested in volunteering:

❑ Daytime_____ ❑ Evening_____ ❑ Weekends_____ ❑ Other _____

EDUCATIONAL BACKGROUND

What is your educational background? _____

_____

PERSONAL INFORMATION

Do you have any relatives working for Hospice of Hope? ❑ Yes ❑ No

If yes, provide names and relationship _____

_____

Do you have any experience with terminally ill and/or bereaved persons? ❑ Yes ❑ No

If yes, briefly explain _____

_____

Have you served in any branch of our Armed Forces? ❑ Yes ❑ No If yes, Branch:_____Years Served: _____

Do you speak a foreign language? ❑ Yes ❑ No What? _____

Do you have a valid driver's license? ❑ Yes ❑ No

Have you ever been convicted of a felony? ❑ Yes ❑ No

CIVIC INVOLVEMENT

List professional, trade, business, or civic associations and offices held. (Exclude memberships which would reveal sex, race, religion, national origin, age, gender identity, color, disability or other protected status.)

_____

_____

OTHER INFORMATION

_____

_____

REFERENCES

List name, address and telephone number of four business/work references or list four school or personal references that are not related to you.

Name	Address	Telephone	Years Known

AREAS OF INTEREST

□ In-Patient Care/Visits
□ Nursing Home Care/Visits
□ Primary Caregiver Relief
□ Veteran Pinning/Visits
□ Shopping/Errands
□ Home Repairs
□ Crafts Making/Delivery
□ Cooking Baking/Delivery
□ Courier Route
□ Snow Brigade (to transport staff)

□ Bereavement Care
□ Fundraising
□ Event Host/Hostess
□ Sewing
□ Music Therapy
□ Gardening
□ Telephoning
□ Writing Cards/Letters
□ Clerical Work

Professional Services
□ Beautician/Barber
□ Massage Therapist
□ Animal Assisted Activity
□ Carpentry
□ Lawn Care

Signature_____Date_____

HOSPICE OF HOPE, INC

Volunteer Agreement

(Volunteer complete and return to Volunteer Coordinator.)

The following information is being asked to best match your profile with the needs/requests of patients/families. This information will remain confidential.

I, _____, agree to serve as a non-paid staff member of Hospice of Hope from _____ until such time as I no longer wish to volunteer or until it is felt that my services are no longer needed. I agree that I am physically able to meet the requirements of a hospice volunteer and I am free of communicable disease. While working as a non-paid staff member, I understand my responsibilities will include those checked below:

_____ Patient Visits and/or telephone calls with patients/families.

_____ Other services that may include transportation, errands, respite or special requests.

_____ Attendance at team meetings, support groups and in-services as needed.

_____ Accurate and up-to-date reporting.

_____ Advance notice of resignation from Hospice of Hope.

_____ Other _____

_____

_____

* * *

Date of Birth: _____

I understand that I will have access to Hospice of Hope patient/family information and that this information is confidential and shall be held in strict confidence. Patient/family information will only be shared with Hospice of Hope personnel.

I have received training for the volunteer responsibilities and believe I can provide volunteer services safely and competently.

In return for my work, I will receive from Hospice of Hope training, continuing education, on-going support and evaluation of my performance as a non-paid staff member.

_____ _____
Signature of Volunteer Date

_____ _____
Signature of Volunteer Coordinator Date

HOSPICE of HOPE

Emergency Contact Information

In case of emergency please contact:

Name: _____ Relation: _____

Address: _____

Home: _____ Cell: _____ Work: _____

In case of emergency please contact:

Name: _____ Relation: _____

Address: _____

Home: _____ Cell: _____ Work: _____

Please list any allergies:

_____

_____

HOSPICE OF HOPE, INC.

Hepatitis B Consent

General Information:

Hepatitis B is a virus-caused inflammation of the liver, which may be passed from one person to another by contact with blood, or body fluids of anyone who has the disease (they may have Hepatitis B unknowingly). ***Any health care worker who may have contact with a patient's infected blood or body fluids is considered at risk for transmission of the disease.*** Short term effects of the disease include loss of work up to three months, and long term effects can include the development of chronic, active Hepatitis and Cirrhosis of the liver.

Hospice of Hope offers the Hepatitis Vaccine at **no cost to you** in our effort to provide a safe environment in the performance of your volunteer duties.

The vaccine will be given at Occupational Medicine at Primary Plus in Maysville, KY. It is a three-interval vaccine given on the starting date, at one month, and at six months per standard routine. Recipients of the vaccine experience local reactions such as soreness, redness, and swelling. These reactions are mild and generally subside within two days of the injection. The vaccine is contraindicated in individuals who are hypersensitive to baker's yeast or those who have had an allergic reaction to a previous dose of the hepatitis B vaccine.

Volunteer Consent/Waiver:

I understand that exposure to blood or other potentially infectious materials may put me at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine at no charge to me.

☐ ***I wish to decline hepatitis B vaccination at this time.*** I understand that by declining this vaccine, I may be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have exposure to blood or other potentially infectious materials and I want to be vaccinated, I can receive the vaccination series at no charge to me.

☐ ***I wish to receive the vaccine after reading the above general information.*** To the best of my knowledge, I am not allergic to yeast. I understand the vaccine series must be started within 10 days of start date.

_____ _____
Volunteer Signature Date

_____ _____
Witness Signature Date

HOSPICE OF HOPE, INC.

Drivers' License Check Permission Form

(Completed by volunteer, retained in personnel file)

Employee Name: _____
PLEASE PRINT NAME

Social Security #: _____ Birth date: _____

Driver's License Number: _____

By my signature below, I do hereby give my consent for Hospice of Hope, Inc. to undergo a driver's license check on an annual basis.

_____ _____
Employee Signature Date

ADMINISTRATIVE OFFICE OF THE COURTS
RECORDS UNIT
1001 VANDALAY DRIVE
FRANKFORT, KENTUCKY 40601
502-573-1682 or 800-928-6381
records@kycourts.net

The process to obtain the information contained in CourtNet is as follows:

Individuals

Requesting a record on yourself requires a $25.00 fee **(check or money order)**. If you do not receive a response in 30 days contact us at the number listed above.

Nonprofit/Commercial/Others

Requesting a record on individuals requires a $25.00 fee **(check or money order)**.

Fees are paid to the order of the KENTUCKY STATE TREASURER by check or money order ONLY. FAILURE TO COMPLY WITH THESE PROCEDURES WILL RESULT IN THE REQUEST BEING RETURNED UNPROCESSED. If you suspect information contained on the record is incorrect, or have any questions, please contact the Records Unit at (502) 573-1682 or (800) 928-6381.

PLEASE **PRINT OR TYPE** THE INDIVIDUAL'S INFORMATION **CLEARLY**.

SOCIAL SECURITY NUMBER: _____ DLN: _____

NAME: _____

MAIDEN NAME(S) AND/OR ALIAS: _____

DATE OF BIRTH: _____

STREET ADDRESS/P.O. BOX: _____

CITY, STATE, ZIP CODE: _____

I understand the information supplied by me must be truthful and falsification with an intent to mislead may result in my prosecution under KRS 523.100. I have provided the basic information necessary to qualify for record processing and exemption of fees - if applicable.

*** ALL INFORMATION BELOW IS REQUIRED.**

_____
Individual's Signature

_____
Date

_____
Company

_____
E-mail address

_____
Requestor/Contact Person

_____
Telephone Number

_____
Address

_____
City, State, Zip

Please denote which purpose applies to this request:

- ☐ Employment
- ☐ Criminal Investigation
- ☐ Screening Housing Applicants
- ☐ Volunteer/Care over Juvenile
- ☐ Licensing
- ☐ Other (please explain) _____

Print Reset Form