Augustana Care Volunteer Application Form

Personal Information
Name ____

Street Address ___________________________ City/State/Zip ________________

Phone (H) ________________ (W) ________________ (C) ____________________

Email _______________________ Preferred method of contact ________________

Church Affiliation (Opt) ______________________ Birthdate ______________

Emergency Contact Name & Phone _____________________________________

Interests, skills, experience
Why are you interested in being a volunteer? ________________________________

____

Job(s) interested in ____

____

Describe your knowledge, abilities and skills and those you want to develop ____

____

Occupation (former or present) ____

If a student, school attending ____

Education and/or special training and certifications __________________________

____

Languages spoken (other than English) _____________________________________

Do you have previous volunteer experience? If so, what? _____________________

____

Do you have experience working with seniors? If so, what? ___________________

____

Are you comfortable with lower functioning residents, including those with memory impairment? ___ Yes ___ No

Interest Checklist

What I like to do	A lot	A little	Not at all
Leading small groups			
Assisting with large groups, including parties, activities and special events			
Organizing programs/events			
Typing/Computer/Newsletter			
Fundraising			
Auxiliary/Board			
Visiting with individuals			
Taking residents for walks, rides, coffee			
Playing cards/games			
Providing instrumental or vocal talent			
Surveying residents			
Staffing a shop (using a register, customer service)			
Sharing a hobby			
Assisting residents with craft projects			
Assisting seniors with daily tasks			
Assisting with outings			
Making/selling popcorn			
Taking residents to church in-house			
Transporting residents to in-house appointments			
Distributing hospitality cart			
Helping prepare/decorate for special days (Christmas, Halloween, etc.)			
Taking initiative to start new projects			
Other ________________________			

Additional Information

Do you have any physical limitations or are you under any treatment which might limit your ability to perform certain types of work? ___ Yes ___ No

If yes, please explain ____

____

Is this volunteer experience for service hours? ___ Yes ____ # of Hours ___ No

For what organization? _________________________________

Times Available (check all that apply)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

What length of time are you willing to commit to volunteering?

____ hours/week 3 months 1 year

____hours/month 6 months Other (describe)

____

References

Please provide two non-family references that we may contact:

Name ______________________________ Relation to you __________________
Address/City/State/Zip ____
Daytime phone _________________________

Name ______________________________ Relation to you __________________
Address/City/State/Zip ____
Daytime phone _________________________

How did you hear about us?

_____ Augustana Care volunteers/employees
_____ Friend/ Relative
_____ Augustana Care Website
_____ Other Internet site/Name ____
_____ Church/Church Name/Affiliation: ____________________________________
_____ Newspaper/phone book
_____ Other: ____

Confidentiality

As an Augustana Care volunteer, I the undersigned, recognize that any information and documents I review in the course of meeting my volunteer responsibilities are to remain in the strictest confidence. No information may be released or discussed except as is necessary for fulfillment of my volunteer responsibilities. Sharing of information, documents, and/or photos requires signed releases for approval of Augustana Care. Failure to comply with the Confidentiality Agreement will result in immediate termination.

Certification

I agree to adhere to the confidentiality policies of Augustana Care, and I declare my answers to the questions of this application are true. I give Augustana Care permission to check my references and information provided.

Volunteer signature ______________________________ Date __________

Parent/guardian signature for volunteers under age 18

____ Date __________

Date Received/Processed : ______________________________________

Augustana Care Corporation

VOLUNTEER AUTHORIZATION TO RELEASE INFORMATION
MINNESOTA BACKGROUND CHECKS

Please print clearly all information
*** Indicates Optional Information**

NAME (First, Middle, Last)

First Middle (full) Last (Maiden)

Date of Birth (month, date and year) Social Security Number (9 digits)

*MN Driver's License # or MN State ID #

Gender: ____M____F *Race:______Caucasian _______African American ______Native American

______Asian _______ Pacific Islander ______Mixed

Current Street Address Apt. #

City State Zip Code

*Phone Number _____ - _______________________________

Other last names I have used:____

I authorize the release of any and all information to Augustana Care Corporation in their background verification of my criminal history. The Minnesota Department of Human Services, Licensing Division is authorized to release to Augustana Care Corporation or its agents any personal information about me relative to the conviction, guilty plea, or nolo contender plea of any crime.
I further understand and waive my rights of privacy in this release of information and hold harmless Augustana Care Corporation and its agents from any liability in this background investigation.
I agree that if any misrepresentation has been made by me herein, or the results of such investigation are not satisfactory, any offer of employment made may be withdrawn, or my employment terminated immediately.
This authorization expires one year from this date.

Signature of Volunteer____Date:___________

Privacy Notice: MINNESOTA DEPARTMENT OF HEALTH LICENSED FACILITIES SUPPLEMENTAL NURSING SERVICES AGENCIES, EDUCATIONAL PROGRAMS, TEMPORARY EMPLOYMENT AGENCIES, PROFESSIONAL SERVICES AGENCIES

BACKGROUND STUDY PRIVACY NOTICE

Because the Minnesota Department of Human Services is requesting that you provide private information about yourself, the Minnesota Government Data Practices Act requires that you be informed of the following:

1. Purpose and intended use of the information: Minnesota Statutes, section 144.057, requires the Minnesota Department of Human Services (DHS) to conduct background studies on individuals who have direct contact with patients and residents in hospitals, boarding care homes, outpatient surgical centers, nursing homes, home care agencies, residential care homes, board and lodging establishments registered to provide supportive or health supervision services, individuals employed by supplemental nursing services agencies, and controlling persons of a supplemental nursing services agency; and all other employees in nursing homes. The background studies are to be completed according to the requirements in Minnesota Statutes, chapter 245C. The information requested will be used to perform a background study of you that will include at least a review of criminal conviction records held by the Minnesota Bureau of Criminal Apprehension and records of substantiated maltreatment of vulnerable adults and children. DHS may also later require you to submit additional information and/or your fingerprints if necessary to complete your background study. For all individuals who are subject to background studies by DHS, the corrections system will report new criminal convictions for disqualifying crimes to DHS. County agencies and the Minnesota Department of Health report substantiated findings of maltreatment of minors and vulnerable adults to DHS.

2. Whether you may refuse or are legally required to provide the information: Minnesota Statutes, chapter 245C, states that the individual who is the subject of a study must provide sufficient information to ensure an accurate background study.

3. Known consequences that may arise from supplying the information: Individuals who have histories with the characteristics identified in Minnesota Statutes, chapter 245C, will be disqualified from positions allowing direct contact with (and, where applicable, access to) persons receiving services. Health-related licensing boards will make a determination whether to impose disciplinary or corrective action on individuals regulated by health-related licensing boards who have been determined to be responsible for substantiated maltreatment. Individuals who do not have disqualifying characteristics will not be disqualified.

4. Known consequences that will arise from refusing to supply the requested information: Only items identified as "optional" may be left blank. Refusal to provide the information necessary to ensure an accurate and complete background study will result in your disqualification and an order to the agency or facility to remove you from any position allowing direct contact with (and, where applicable, access to) persons receiving services.

5. Identification of other agencies or entities authorized to receive this information: The information you provide will be shared with the Minnesota Bureau of Criminal Apprehension. If DHS has reasonable cause to believe that other agencies may have information pertinent to a disqualification, the information may also be shared with county attorneys, county sheriffs, courts, county agencies, local police, the Federal Bureau of Investigation, the Office of the Attorney General, agencies with criminal record information systems in other states, and juvenile courts. Background study results may be shared with the Minnesota Department of Health, the Minnesota Department of Corrections, the Office of the Attorney General, non-licensed personal care provider organizations, and health-related licensing boards. If you have a disqualifying characteristic, the facility will be told only that you are disqualified and will not be told what caused your disqualification, unless you were disqualified for refusing to cooperate with the background study or for serious and/or recurring maltreatment of a minor or vulnerable adult. The information about you received as part of a background study is classified as private data and, except for the agencies noted, cannot be shared without your consent.