



11270 Rough and Ready Highway, Grass Valley, CA 95945
530-272-5739 FAX 530-272-0328

Volunteer Application Professional Services Volunteer

Thank you for considering Hospice of the Foothills as an opportunity for volunteering. We appreciate you choosing this agency as one of your volunteer choices. When complete, please return to Hospice of the Foothills, Attn: Volunteer Coordinator.

I, the applicant, understand that Hospice of the Foothills expects a one year commitment to service a maximum of one 4-hour shift per week. I understand that attendance at weekly Patient Support Volunteer Team Meetings and monthly in-services (continuation training) are important to effective service.

If further understand that it is the policy of Hospice of the Foothills to perform background checks on all volunteers associated with this agency. Also required will be a health exam provided by our agency physician and TB testing both to be at the expense of this agency. Proof of California Driver's License and liability insurance may also be required.

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: Home _____ Work _____ Cell _____

Mailing Address (if different) _____

What type of direct patient volunteering are you interested in and do you have special skills, degrees or certificates? Would you be willing to include this craft/education in your volunteer experience? Copies of professional degrees or certificates, if applicable, will be required.

- Respite Bereavement Facilitator Handyman
- Bereavement Counseling Foreign language _____
- Bodywork(massage) Beautician/Barber Other

Have you ever been convicted of a felony? yes no. If yes, please explain _____

Do you have any physical limitations? If yes, please explain _____

Person to notify in the event of emergency _____

Phone#:() _____ Alternate Phone#:() _____

Volunteer Application
Office/Clerical Worker

Please list three personal or professional references that you are unrelated to:

Name: _____ Phone# _____

Address: _____

City State Zip

Name: _____ Phone# _____

Address: _____

City State Zip

Name: _____ Phone# _____

Address: _____

City State Zip

Volunteer Application – Direct Patient Support

Please respond to the following questions as thoughtfully and completely as you can, exploring your feelings and intentions. Be certain to cover all the points indicated and respond to each question individually.

Do you have previous volunteer experience? _____
If yes, please describe briefly. _____

What motivated you to apply for a volunteer position with Hospice of the Foothills? _____

What do you expect to gain from being a member of Hospice's Patient Support Volunteer Team? _____

What are your feelings about and understanding of pain management? _____

Because volunteer training is a major commitment of time and effort for both you and our agency, we would like to know if you anticipate anything which may interfere with fulfilling the one year commitment to Hospice of the Foothills, e.g., family obligations, possible plans for relocation, future study, employment? _____

Have you experienced a significant loss (death, divorce, serious illness) or any other event which has caused you significant stress during the past year? Did you have a role in this process and, if yes, please explain? _____

Hospice works with people with cancers, AIDS, dementia, as well as other non-cancer diagnoses and prognoses. How would you feel about being with someone who had serious physical limitations or altered appearances resulting from their illness or its treatment?_____

Volunteers provide emotional and practical support for people experiencing living and dying with a terminal illness. What kinds of patients or situations would you anticipate having the most difficulty with and why?_____

What is your feeling about working with patients and patient families of a different race, religion, economic and/or spiritual background?_____

Is there any particular situation in which you would not feel comfortable when working as a Hospice volunteer?_____

What is your support system and how do you care for yourself?_____

Describe your personal experience with grief and your feelings about the grieving process._____

Professional Services Volunteer Commitment

As a patient support volunteer team member of Hospice of the Foothills, I agree to:

- ❖ show my team support and involvement through attendance at weekly patient support meetings regardless of whether or not I have a current assignment;
- ❖ attend monthly in-services which provide me with continuation training.

- ❖ When accepting an assignment I agree to:
 - ❖ maintain contact with the Volunteer Coordinator, informing her of any changes in my availability and/or time constraints;
 - ❖ discuss problems incurred while working with a patient and/or family;
 - ❖ keep the Volunteer coordinator informed of personal issues that interfere with my ability to perform responsibilities in an appropriate manner;
 - ❖ maintain communication with Hospice of the Foothills' team and the patient/family to whom I have been assigned throughout the assignment, sharing and receiving appropriate information as necessary;
 - ❖ maintain accurate documentation (Volunteer Visit Record) of all contacts including phone calls with my patient and/or family, and submit these progress notes to the Volunteer Coordinator in a timely fashion (same day is best but within 48 hours of contact). Postage paid envelopes are provided by Hospice of the Foothills.

In applying for this volunteer position with Hospice of the Foothills, I acknowledge and agree to provide the following:

- ❖ Health exam (frequency as determined by state and federal regulations).
- ❖ TB testing (frequency as determined by state and federal regulations).
- ❖ Hep B series (or signed waiver).
- ❖ Current California Driver's License (as required by HOF liability insurance carrier).
- ❖ Current automobile liability insurance including liability limits of \$100,000 each person, \$300,000 each occurrence (as required by HOF liability insurance carrier).

I agree to respect the confidentiality of all information (as required by the Health Insurance Portability and Accountability Act of 1996, HIPAA) acquired in the course of my work and to respect the patient/family belief systems, as well as their freedom to determine the type of care they wish to receive.

I understand that my commitment in being accepted by this program will include acknowledgement and acceptance of Hospice of the Foothills' mission, philosophy, policies and procedures. My services as a volunteer may be terminated for failure to comply with these standards.

In return for my work as a volunteer I will receive from the HOF staff, appropriate training, continuing education, on-going support, supervision, encouragement, guidance and recognition.

Volunteer Name/Signature

Date