11270 Rough & Ready Highway, Grass Valley, CA 95945

Volunteer Application

Professional Services Volunteer

Thank you for considering Hospice of the Foothills as an opportunity for volunteering. We appreciate the time and thought involved in completing this application. When you have completed the application, 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 serve a maximum of one 4-hour shift per week. I understand that attendance at monthly Patient Support Volunteer Team Meetings and monthly in-services (continuation training) are important to effective service.

I, further understand that it is the policy of Hospice of the Foothills to perform background checks on all volunteers associated with this agency.

NAME:_____Date:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP_____

PHONE:Home:_____Work:_____Cell:_____

EMAIL ADDRESS:_____

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

Do you have any physical limitations ☐ YES ☐ NO. If yes, please explain_____

_____

Person to notify in the event of an emergency (1 of 2):

NAME:_____

PHONE #:(__)_____ALTERNATE PHONE#(__)_____

Person to notify in the event of an emergency: (2 of 2)

NAME:_____

PHONE #:(__)_____ALTERNATE PHONE#(__)_____

Please list three personal or professional references that you are unrelated to. Complete address is required.

NAME:_____PHONE #:_____

ADDRESS:_____

_____
City state zip code

NAME:_____PHONE #:_____

ADDRESS:_____

_____
City state zip code

NAME:_____PHONE #:_____

ADDRESS:_____

_____
City state zip code

NOTE:
References letters are mailed out; so complete, accurate (easily legible) and current addresses are needed please.

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

Do you have previous volunteer experience? ☐ YES ☐ NO
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 cancer, AIDS, dementia, as well as other non-cancer diagnoses and prognoses. How would you feel about being with someone who has 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._____

DIRECT PATIENT SUPPORT 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 monthly 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/caregivers.
- 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 which 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 immediately after visit/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 Hospice of the Foothills liability insurance carrier).
- Current automobile liability insurance including liability limits of $100,000 each person, $300,000 each occurrence (as required by Hospice of the Foothills liability insurance carrier). If offering transportation for patients/family members a combined single liability limit of $300,000. is required.

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 Hospice of the Foothills staff appropriate training, continuing education, on-going support, supervision, encouragement, guidance and recognition.

_____

Volunteer Name/Signature Date

TITLE: **Patient Care Support Volunteer**

RESPONSIBLE TO: Volunteer Coordinator

POSITION SUMMARY: This volunteer is part of a peer/lay group who is specially trained to provide the patient/family unit with emotional and practical support through the illness and until the death of the patient.

QUALIFICATIONS:

1. Familiar with and committed to Hospice philosophy and interdisciplinary team approach to patient services.
2. Must have an interest in and desire to serve Hospice of the Foothills' patients and their families.
3. Must be sensitive to personal issues relating to death, dying, loss and grief of hospice patients and caregivers and within personal and professional boundaries.
4. Must support the dignity and uniqueness of the patient/family and of its need to find its own way to meet the challenges of terminal illness and grief.
5. Must have the ability and desire to work within the interdisciplinary team model of care.
6. Must be reliable, autonomous, flexible and non-judgmental in relation to diverse lifestyles, living conditions, organized religions, spiritual beliefs, national origins, gender and sexual orientation.
7. Demonstration of good communication and interpersonal skills and ability to work supportively in a team approach.
8. Resolution of significant trauma (death, divorce, serious illness) in his/her own life. Hospice of the Foothills policy requires a waiting period of one year after such a serious experience.
9. Excellent physical and mental health.
10. Possession of a valid California driver's license, a reliable automobile and proof of current liability insurance and limits described by Hospice of the Foothills policy.

DUTIES AND RESPONSIBILITIES:

1. The volunteer will complete the Hospice of the Foothills volunteer training program in its entirety or have documentation stating completion of a comparable hospice training course that is transferable.
2. As a member of the Inter-Disciplinary Team the volunteer will adhere to the Plan of Care as it pertains to volunteer services.
3. The volunteer will be willing to serve hospice patients/families in their homes, skilled nursing facilities, and residential care facilities or by phone without monetary compensation.
4. The volunteer will make a one year commitment, with an average of four hours per week when assigned to a Hospice family.
5. The volunteer will attend Patient Support monthly team meetings (especially when on a case).
6. The volunteer will attend a minimum of two monthly in-services (continuing education) per year.

DUTIES AND RESPONSIBILITIES (cont.):

7. The volunteer will maintain weekly contact with the Volunteer Coordinator throughout the assignment to share and receive appropriate information.
8. The volunteer shall maintain weekly contact with the assigned family/caregiver via telephone check-ins and/or in-person visits.
9. The volunteer will document all tasks performed (including phone contacts) and miles traveled. Documentation will be submitted to the Volunteer Coordinator within 48 hours of the contact.
10. The volunteer will demonstrate an understanding and proper use of Standard Precautions.
11. The volunteer will maintain strict confidentiality with respect to Hospice of the Foothills' families in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
12. Comply with all Hospice Policies and Procedures, current or future, and any other issues contained within the training program, current or future.
13. The volunteer will inform the Volunteer Coordinator of any changes in availability and/or time constraints, discuss problems incurred while working with a patient and/or family and any personal issues that may interfere with the volunteer's ability to perform responsibilities in an appropriate manner.
14. The volunteer will complete and renew annually TB testing.
15. The volunteer will participate in annual evaluation process provided by the Volunteer Coordinator.
16. Duties may include but are not limited to:
    - Providing respite to a caregiver or family member
    - Reading to patient
    - Listening to patient
    - Companionship for patient
    - Preparing light meals (sandwich, warming pre-made dinner)
    - Feeding the patient
    - Light housekeeping (straightening the bedside, patient's meal dishes)
    - Running errands
    - Transportation to medical appointments, grocery shopping, etc., provided minimum automobile liability requirements of $300,000/$300,000 are met.

By signing below, I acknowledge that I understand the duties and responsibilities of a Patient Care Support Volunteer and the guidelines by which one is expected to operate. I agree to follow these guidelines to the best of my ability.

_____	_____	_____
Print Name	Signature	Date