



LOCAL HELP FOR PEOPLE WITH MEDICARE

Volunteer Application

Personal Information

Name					
Street Address					
Mailing Address					
City ST ZIP Code					
Home Phone		Cell Phone		Work Phone	
E-Mail Address				Date of Birth	

Employment

Employer (current or former, if retired)

Supervisor Name

Phone

Position

Education

High School

College

Graduate School

Current Student

Current students: Would your volunteer work be related to a school project or requirement? Yes No If so, describe:

Availability

How many hours are you available for volunteer assignments?

Number of hours per week: _____ Number of hours per month: _____

Check the days and times you are available for volunteer assignments:

	Monday	Tuesday	Wednesday	Thursday	Friday
Mornings					
Afternoons					

Interests

Tell us in which areas you are interested in volunteering

___ Data entry

___ Special events

___ Counseling on Medicare

___ Help with billing issues

___ Public speaking

___ Outreach

___ Fraud

___ Other



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Special Skills or Qualifications

Summarize special skills and qualifications you have acquired from employment, previous volunteer work, or through other activities, including hobbies or sports.

Two horizontal lines for text entry.

Other than English, what languages can you speak, read or write?

Language: _____ ___ Speak ___ Read ___ Write

Language: _____ ___ Speak ___ Read ___ Write

Language: _____ ___ Speak ___ Read ___ Write

Are you willing to serve clients who speak these languages in their own language? Yes No

Previous Volunteer Experience

Summarize your previous volunteer experience.

Three horizontal lines for text entry.

References

Name:	Phone:
Relationship:	Length of time known:
Name:	Phone:
Relationship:	Length of time known:
Name:	Phone:
Relationship:	Length of time known:



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Person to Notify in Case of Emergency

Name	
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	

Background Check

Your volunteer capacity with the SHIBA program may involve unsupervised contact with vulnerable adults and/or developmentally disabled people. Therefore, as required by the Idaho State Police National Child Protection Act of 1993, as amended in 1994 to include elderly and disabled persons, you are requested to complete and sign before a witness the attached Waiver Agreement and Statement in order for SHIBA to request Idaho and FBI criminal history checks.

Agreement and Signature

NONAFFILIATION – CONFLICT OF INTEREST: I do not have an active insurance license, and I am not currently employed by a health insurance company, agency or service, nor am I in a position to sell or receive commissions from health insurance products or services or to use my SHIBA affiliation for purposes of personal financial gain.

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, intentional omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

I further understand that all statements I make in response to any inquiry are subject to investigation and verification prior to appointment.

Name (printed)	
Signature	
Date	

Our Policy

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Thank you for completing this application form and for your interest in volunteering with us.