STATE OF HAWAII
DEPARTMENT OF HEALTH
EXECUTIVE OFFICE ON AGING
LONG TERM CARE OMBUDSMAN
VOLUNTEER PROGRAM
NO. 1 CAPITOL DISTRICT
250 SOUTH HOTEL STREET, SUITE 406
HONOLULU, HAWAII 96813

Volunteer Application Form II

CONTACT INFORMATION

Applicant Name: _____ Date: _____

Home Address: _____

Island /State: _____ Zip code _____

Primary Phone Number: _____ Cell: _____

Email address: _____ FAX _____

Best method / times to contact you:

_____

Name of Emergency Contact/Relationship: _____

Contact information for Emergency Contact: _____

APPLICANT INFORMATION

1- Have you ever been inside a nursing home, residential care home or assisted living facility?

☐ YES ☐ NO

If yes, please describe your experience:

2-Do you have relatives or friends closely connected with a nursing facility, residential care home or assisted living facility?

☐ YES ☐ NO

3- Have you ever been employed by a nursing facility, residential care home or assisted living facility? How long did your work there?

What were your job duties?

Why did you leave?

4. Are you willing and able to make a one year commitment to volunteer with the Ombudsman Program?

☐ YES ☐ NO

5. Are you proficient in more than one language?

☐ YES ☐ NO

Please list the languages: _____

6. What questions/concerns do you have about the volunteer position?

7. This volunteer position requires that you work with vulnerable adults. We require a criminal background check on all volunteers. Do you agree to have our office conduct a criminal history check?

☐ YES ☐ NO

By signing this application form, you are agreeing to allow our office to conduct a criminal history check. Upon receipt of this signed application form, our office will contact you for the information needed to conduct the criminal history check. Failure to provide consent or the information required in this consent form will result in the denial of opportunity to volunteer with the Long Term Care Ombudsman Volunteer Program.

If you have lived in another state(s), please provide our office with a copy.

8. List any previous volunteer experience that you have had. Please include the organization, your involvement and the length of time you volunteered:

REFERENCES

9. Please list three references that we may contact. These should not be relatives but could be teachers, employers or other community members.

Name: _____ Relationship: _____

Address: _____ Phone #: _____

How does this person know you? _____

Name: _____ Relationship: _____

Address: _____ Phone #: _____

How does this person know you? _____

Name: _____ Relationship: _____

Address: _____ Phone #: _____

How does this person know you? _____

10. Please describe any skills, hobbies or experience that would enable you to perform the duties/responsibilities of a LTCO volunteer

11. Are there any medical, physical or cognitive conditions that may affect your ability to function as a LTCOP volunteer? (If Yes, please indicate the condition and how it may hamper your performance to carry out your responsibilities as a volunteer)

12. How did you learn about the LTCO Program?

Volunteer Assurances

As a volunteer Ombudsman, I understand that the program requires a commitment to the ideals of the program that have been explained to me and I provide assurances that I will comply with these ideals as stated below:

I am at least 21 years of age	YES	☐	NO	☐
I have reliable transportation	YES	☐	NO	☐
I agree to be impartial	YES	☐	NO	☐
I agree to be tactful, diplomatic and non judgmental	YES	☐	NO	☐
I will be reliable and conscientious	YES	☐	NO	☐
I agree to be respectful of residents' preferences and cultural views	YES	☐	NO	☐
I am able to read, write and communicate in English	YES	☐	NO	☐
I will listen objectively without inserting my personal values when visiting residents	YES	☐	NO	☐
I have no family or friends residing in the facility that I will volunteer in	YES	☐	NO	☐
I agree to participate in a criminal background check	YES	☐	NO	☐
I understand that the work I do is confidential. I will not share any information about complaints, records, facilities, residents or staff with anyone outside the Ombudsman program	YES	☐	NO	☐
I agree not to express an opinion about the quality of specific long-term care facilities to the public, family or friends	YES	☐	NO	☐
I agree to complete the paperwork in a timely manner as identified by my supervisor	YES	☐	NO	☐
I do not have financial, personal or professional conflict of interest with long-term care facilities	YES	☐	NO	☐

I certify the information provided on this application is true, complete and accurate to the best of my knowledge. I authorize the representatives from the Long Term Care Ombudsman Program to contact my references. I also authorize the persons referenced to provide information in connection with my application and release them from any liability.

PRINT NAME : _____

SIGNATURE: _____

DATE: _____

COMMENTS: