

# HOPE FAMILY CARE CENTER

## VOLUNTEER FORM CHECK LIST

HAVE YOU COMPLETED AND RETURNED:

- 1 Volunteer Application \_\_\_\_\_
- 2 Health Survey \_\_\_\_\_
- 3 Authorization to Release Information \_\_\_\_\_
- 4 Safe Conduct Certification \_\_\_\_\_
- 5 HIPAA Compliance \_\_\_\_\_
- 6 General Guidelines \_\_\_\_\_
- 7 This Volunteer Check List \_\_\_\_\_

THANK YOU FOR YOUR INTEREST IN VOLUNTEERING WITH US AT  
HOPE FAMILY CARE CENTER.



Family Care Center

# Volunteer Application

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ (last) \_\_\_\_\_ (first) \_\_\_\_\_ (MI)  
 Title:  MD/D.O.  D.P.M.  N.P./P.A.  R.D.H.  R.N./L.P.N.  C.N.A.  D.D.S.  M.S.W.  Other

Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
 License Number: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_

Where Employed: \_\_\_\_\_

Hospital Affiliation: \_\_\_\_\_

Professional Memberships: \_\_\_\_\_

Social, Business Activities: \_\_\_\_\_

Other Volunteer Activities: \_\_\_\_\_

Please check from the opportunities below that most interest you:

- Physician
- Physician Assistant
- Nurse Practitioner
- Pharmacist
- Spanish Translator
- House Cleaning
- Dentist
- RN-LPN-FMT
- Secretarial
- Clergy-Prayer Partner
- Dietitian
- ASL Interpreter
- Marketing/PR
- Dental Assistant or Hygienist
- Social Worker
- Medical Assistant
- Health Educator
- Medical Records
- Administration
- Grant Writing

Please list name and phone number of two personal references:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Please mail this form to:

**HOPE**  
 Family Care Center  
 PO Box 713  
 509 N. Peru St.  
 Cicero, IN 46034

Phone: 317-984-3444

Or Fax to: 317-984-5707

HEALTH SURVEY QUESTIONNAIRE

A review of health status is required of all clinic volunteers. Hepatitis B vaccination and PPD placement will be provided for free if done through our clinic. It may also be done by your private physician. In either case, this form should be filled out and turned into the Executive Director.

Name of Volunteer: \_\_\_\_\_

Health Status and History

1. Do you currently have any physical or mental impairment that could limit your ability to volunteer?  Yes  NO
2. Are you currently taking medications that could limit your ability to volunteer?  Yes  NO
3. Do you have a potentially contagious disease?  Yes  NO
4. Have you been hospitalized for any reason during the last 5 years?  Yes  NO
5. Are you currently or have you ever been under formal mental health therapy or treatment?  Yes  NO
6. Are you currently under or have you ever received treatment for an alcohol or drug related condition?  Yes  NO
7. Have you ever been involved in the unlawful use of controlled substances?  Yes  NO

Comments: \_\_\_\_\_

PPD Screening

1. Date of last PPD  Positive  Negative  No
2. Have you ever had pulmonary tuberculosis?  Yes  No
3. Have you ever received prophylactic treatment?  Yes  No

If your last PPD skin test was negative and the date is more than one year ago, you will need a PPD skin test. If you had a positive PPD skin test (>10mm induration) then you must be asymptomatic and have your most recent CXR without active TB.

FOR OFFICE USE

This volunteer was given a PPD skin test on \_\_\_\_\_

Test results:  Positive  Negative  No

Read by: \_\_\_\_\_ (Print)  
 Procedure in case of positive results: \_\_\_\_\_ (Signature)

HEPATITIS B SCREENING

1. Date of last Hepatitis B vaccination: \_\_\_\_\_
2. Have you ever had Hepatitis?  Yes  No
3. Have you ever received prophylactic treatment?  Yes  No

If yes, give date and type: \_\_\_\_\_

Volunteer Signature: \_\_\_\_\_

Date: \_\_\_\_\_

FOR OFFICE USE

I have assessed this history and found this person to be:

- With physical problems which would limit ability to volunteer.
- With physical problems which do not involve communicable disease or the ability to volunteer.
- In good health and free of communicable disease.

(Print Name- Executive Director) \_\_\_\_\_

(Signature- Executive Director) \_\_\_\_\_

(Date) \_\_\_\_\_

**HOPE**  
Family Care Center  
HOPE FAMILY CARE CENTER  
PO Box 713  
509 N. Peru St.  
Cicero, IN 46034

317-984-344 Fax: 317-984-3444

Dear Volunteer,

Your consent is requested for the following:

1. I authorize HOPE Family Care Center, Inc. to print my name as a volunteer in information published by HOPE Family Care Center, Inc (i.e.: Brochures, Website, Marketing Publications, etc.)  
 Yes  No
2. I authorize HOPE Family Care Center, Inc. to display my name on all volunteer recognition items.  
 Yes  No
3. I authorize my birthday to be listed for staff and healthcare volunteers to see.  
 Yes  No

Birthday \_\_\_/\_\_\_/\_\_\_

(Print name) \_\_\_\_\_  
(Title) \_\_\_\_\_  
(Date) \_\_\_\_\_  
Signature: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

AUTHORIZATION TO RELEASE  
VOLUNTEER INFORMATION

**HOPE FAMILY CARE CENTER**  
 HOPE  
 PO Box 718  
 509 N. Peru St.  
 Cicero, IN 46034

Phone: 317.984.3444 ♦ Fax: 317.984.5707

**SAFE CONDUCT CERTIFICATION AND AUTHORIZATION FORM**

To demonstrate the pro-active concern of the HOPE Family Care Center, Inc. for the safety of children entrusted to its care, the Board of Directors of HOPE Family Care Center, Inc. require that Board Members, Paid Staff, and Volunteers certify that they are free of suspicions of child abuse. The HOPE Family Care Center, Inc. and its advisors seek the following information for internal use.

1. Has any criminal charge, alleging sexual or other forms of child abuse, ever been filed against you by any child protective agency, prosecutor, or other public authorities in Indiana or elsewhere?

YES \_\_\_\_\_ NO \_\_\_\_\_

2. Has any demand for payment of damages ever been made against you, or has any civil lawsuit ever been filed against you in Indiana or elsewhere seeking damages for alleged sexual or other forms of child abuse?

YES \_\_\_\_\_ NO \_\_\_\_\_

3. Have you ever left or been removed from employment or from a volunteer position or been disciplined by any employer or organization because of charges of sexual or other forms of child abuse?

YES \_\_\_\_\_ NO \_\_\_\_\_

4. If you answer "YES" to any of the above questions you will be contacted by a HOPE Family Care Center representative to determine appropriate volunteer opportunities available to you at the clinic.

I certify that my answers to the above questions and any statements of explanation made by me on the form or any attached pages are true and accurate. I hereby recognize my duty and agree to make amendments to my answers above if there is a change of circumstance that renders my answers above untrue or incorrect. I hereby consent and grant permission to HOPE Family Care Center, Inc. authorities to obtain, for internal use only, any additional information relating to the information sought in this Consent form all pertinent organizations and individuals. I waive and release any and all claims I might have against any parties making such disclosures. I also waive and release any and all claims I might have against Cicero Christian Church, all Church organizations and HOPE Family Care Center, Inc. representatives relating to any such disclosures from third parties.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

I have received and read the HOPE Family Care Center Protocol for Care of Minors

Initial \_\_\_\_\_

**HOPE**  
HOPE FAMILY CARE CENTER  
PO BOX 713  
509 N. Peru St.  
Cicero, IN 46034  
*Family Care Center*

Phone: 317.984.3444 Fax: 317-984-5707

### Acknowledgment of HIPAA Compliance Mandates for HOPE Family Care Center, Inc.

By signing below, I hereby agree to the Healthcare Portability and Administrative Requirements of HOPE Family Care Center, Inc. effective within the privacy standards February 21, 2004. Within HOPE Family Care Center, Inc. entities I agree to:

→ Follow HOPE Family Care Center, Inc. policies related to privacy and protection of patient protected healthcare information (PHI) when conducting business within the facility or entity of HOPE Family Care Center, Inc.

→ Follow the minimum necessary regulation of HIPAA as defined within my job classification to include information needed to perform treatment and carry out the accepted use of payment, treatment or healthcare operation as an employee or volunteer of HOPE Family Care Center, Inc.

→ Maintain the necessary safeguards to protect patient information from disclosure by keeping information away from view, kept in secure areas when stored, and destroyed when no longer necessary.

→ Be solely responsible when taking information generated by HOPE Family Care Center, Inc. off the premise, which leads to an incidence of inappropriate disclosure. I understand this will likely lead to immediate dismissal/legal repercussion based on HIPAA regulatory sanctions.

→ Contact the appropriate Privacy Officer for further clarification or authorization when using PHI for any reason other than payment, treatment, or healthcare operations.

→ Keep Protected Healthcare Information from disclosure to outside vendors unless the appropriate agreements are signed allowing such disclosures.

→ Follow the Notice of Privacy Practices established for HOPE Family Care Center, Inc. effective February 21, 2004.

Signature of Volunteer

Date

Print Name



### General Guidelines for Volunteers

Hope Family Care Center provides a volunteer opportunity for those who desire to follow the model of Christ.

I have given a model to follow, so that as I have done for you, you should also do.

John 13:15

#### WE WILL:

- Post monthly volunteer schedules at the clinic for sign-up.
- E-mail or text volunteer opportunities to you.
- E-mail or text reminders prior to your sign-up date.
- Provide training, when necessary.

#### WE HOPE YOU WILL:

- Notify your volunteer scheduling coordinator of the dates you are unavailable to volunteer. We will not contact you for those dates.
  - If you need to cancel at the last minute, please leave a voice mail message. Clinic voice mail is checked prior to the start of each clinic.
  - HIPPA guidelines and professional trustworthiness is of primary importance to the clients we serve. Your confidential respect for the privacy of client information is required.
  - Pray for the clients who will be served through the efforts of all those involved with the clinic.
- Whatever you ask for in prayer with faith, you will receive.

Mathew 21:2

#### DRESS:

- In order to help our clients feel comfortable, we recommend casual dress; appearance must be clean and neat. Scrubs, jeans with a scrub jacket or lab coat are acceptable.
- Name tags are provided and should be worn by all staff members.

Thank you for your desire to share your time and talents with our brothers and sister in our community. We hope you find this a rewarding experience and invite others who have a heart for serving to join us.

Signature \_\_\_\_\_

Date \_\_\_\_\_