



AWS Staff Member: \_\_\_\_\_

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

Current Volunteer

Interested in Volunteering

Volunteer Application  
(please print legibly)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Date of birth (MM/DD/YR: (\_\_\_ / \_\_\_ / \_\_\_))

E-mail: \_\_\_\_\_

How would you like to be contacted?  Phone  Email

Emergency Contact Information:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Work and Volunteer Experience:

Past experience: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Degree: \_\_\_\_\_

Special Training: \_\_\_\_\_

Special Skills: \_\_\_\_\_

Interests and Hobbies: \_\_\_\_\_

List computer programs you are skilled in:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Time of day when available?  Morning  Afternoon  Evening

How many days a week/month are you available? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Areas of Interest:**

- Advisory Committee
- Café Host
- Club Leader/Helper
- Computer Instructor
- Data Entry
- Fitness Room Assistant
- Fundraising/Advisory Committee
- Front desk-Security
- Helping Hands for LifeCircles—games & activities, one-on-one interaction with clients
- Meals on Wheels Driver
- Host/Greeter for special events
- Medicare/Medicaid Counselor (training provided)
- Office support
- Running copies/envelopes/letters/menus
- Senior Medical Transportation
- Special Events
- Teaching a class
- Tour guide

Do you have any health limitations that may affect your volunteer duties? \_\_\_\_\_

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- Are you willing to drive your own vehicle within the county?     Yes             No
- Have you had any major accidents or traffic violations?         Yes             No
- Do you have medical insurance?                                         Yes             No
- Do you have liability insurance (auto and/or homeowners)?     Yes             No

It is the policy of AgeWell Services to conduct a standard background check on each team member and volunteer through the Michigan State Police system, iChat prior to working with the agency. In the event an applicant has been convicted of a crime, the Director may conduct an investigation in accordance with fair standards and procedures to determine if the prior conviction should disqualify the person from volunteering.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*AgeWell Services retains the exclusive right to determine whether the volunteer's performance is satisfactory to the agency. It also retains the right to determine whether to reassign or end any volunteer services.*



(231) 755-0434

Toll free: 1-800-442-6769

[www.agewellservices.org](http://www.agewellservices.org)

### Volunteer/Guest Release and Waiver of Liability Form

This Release and Waiver of Liability (the “release”) releases AgeWell Services of West Michigan, (“Nonprofit”), a nonprofit corporation organized and existing under the laws of the State of Michigan and each of its directors, officers, employees and agents. The Volunteer/Guest desires to provide volunteer/guest services for AgeWell Services and engage in activities related to serving as a volunteer/guest.

As a Volunteer/Guest, I understand that the scope of the Volunteer’s or Guest’s relationship with AgeWell Services it is limited to a volunteer/guest position and that no compensation is expected in return for services provided by Volunteer/Guest; that AgeWell will not provide any benefits traditionally associated with employment to Volunteer/Guest; and that Volunteer/Guest is responsible for his/her own insurance coverage in the event of personal injury or illness as a result of Volunteer’s/Guest’s services to AgeWell.

1. Waiver and Release: I, the Volunteer/Guest, release and forever discharge and hold harmless AgeWell Services and its successors and assigns from any and all liability, claims, and demands of whatever kind of nature, either in law or in equity, which arise or may hereafter arise from the services I provide to AgeWell. I understand and acknowledge that this Release discharges AgeWell from any liability or claim that I may have against AgeWell Services with respect to bodily injury, personal injury, illness, death, or property damage that may result from the services I provide to AgeWell or occurring while I am providing volunteer/guest services.

2. Insurance: Further I understand that AgeWell does not assume any responsibility for or obligation to provide me with financial or other assistance, including but not limited to medical, health, or disability benefits or insurance. I expressly waive any such claim for compensation or liability on the part of AgeWell Services beyond what may be offered freely by AgeWell in the event of injury or medical expenses incurred by me.

3. Medical Treatment: I hereby Release and forever discharge AgeWell from any claim whatsoever which arises or may hereafter arise on account of any first-aid treatment or other medical services rendered in connection with an emergency during my tenure as a volunteer/guest with AgeWell Services.

4. Assumption of Risk: I understand that the services I provide to AgeWell may include activities that may be hazardous to me including, but not limited to slip and falls or dog bites. As a volunteer/guest, I hereby expressly assume risk of injury or harm from these activities and Release AgeWell Services from all liability.

5. Photographic Release: I grant and convey to AgeWell all rights, title, and interests in any and all photographs, images, video, or audio recordings of me or my likeness or voice made by AgeWell Services in connection with my providing volunteer/guest services to AgeWell Services.

6. Other: As a volunteer/guest, I expressly agree that this Release is intended to be as broad and inclusive as permitted by the laws of the State of Michigan and that this Release shall be governed by and interpreted in accordance with the laws of the State of Michigan. I agree that in the event that any clause or provision of this Release is deemed invalid, the enforceability of the remaining provisions of this Release shall not be affected.

By signing below, I express my understanding and intent to enter into this Release and Waiver of Liability willingly and voluntarily.

\_\_\_\_\_  
Signature (Or parent/guardian if under 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Volunteer/Guest

Updated 5/21/19

## What is HIPAA?

HIPAA is a Federal Law that was brought about to help people manage their Personal Health Information (PHI) that is obtained by various businesses in the course of doing business with them. (Ex. – doctor’s offices, hospitals, Hospice, home care services, etc.) It also limits what those businesses can do with your information.

## Why do we have to comply with HIPAA?

Under the American Recovery and Reinvestment Act of 2009 our Agency now has more responsibility as far as reporting breaches and we can now be penalized for any breaches that occur. We can now be fined from \$10,000 up to \$1.5 million, depending on the type of breach.

## What is considered Personal Health Information (PHI)?

First or last name	Date of birth	Member, certificate or
Address	Phone and fax number	account numbers
Employer	E-mail address	Photos or fingerprints
Relative’s names	Social Security Number	Service or billing codes

Any other information which may identify the individual: the reason client is under our program, the medications he or she receives, and information about past health conditions.

## What is considered a reportable “breach”?

Breach - the unauthorized acquisition, access, use, or disclosure of unsecured PHI which compromises the privacy of such information for the individual.

Examples: discussing client names/information, etc., client record documents left in view of public or visitors, papers containing PHI found offsite – such as in trash (not shredded) or after a vehicle is involved in a break-in or an accident, papers fall out of a bag or briefcase, or mailing client information to the wrong address

## What are some things I should do?

- Do not discuss client names with ANYONE outside the agency.
- Only talk about confidential client information in a private place (i.e. behind a closed door)
- Close files/charts when not in use.

Please sign below and return with your volunteer application. Please call with any questions, 231-559-0476. Thank you.

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I verify that I have read and understood the HIPAA information and what I must do to ensure client information is kept confidential. Failure to do so may result in dismissal.

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Signature

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Date



## RELEASE OF INFORMATION

It is the policy of AgeWell Services to conduct a standard background check on each team member and volunteer through the Michigan State Police Criminal History Log and National Sex Offender Registry prior to working with the agency.

This policy is mandated to us by our funders; Senior Resources of West Michigan and the Office of Services to the Aging for the State of Michigan.

The following information is needed to complete the check:

Full name: \_\_\_\_\_

Ethnic Background:

American Indian    Asian Pacific Islander    Black    Hispanic    White

Sex:  Male    Female

Date of Birth (MM/DD/YY): \_\_\_\_\_

Other name you may have been known by (i.e. maiden name): \_\_\_\_\_

Thank you for your cooperation.

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

AgeWell Services of West Michigan  
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(231) 755-0434  
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