AWS Staff Member: _____

Date: _____

Current Volunteer ☐

Interested in Volunteering ☐

Volunteer Application
(*please print legibly*)

Volunteer Information:

Chosen Name: _____ Legal Name: _____

Address: _____

_____

Phone: _____

Date of birth (MM/DD/YR: (___ / ___ / ___)

E-mail: _____

How would you prefer to be contacted? ☐ Phone ☐ Email

Emergency Contact Information:

Name: _____

Phone: _____ Relationship to Volunteer: _____

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:

- ☐ Meals on Wheels Driver
- ☐ AgeWell Senior Transportation Driver
- ☐ AgeWell Senior Transportation Dispatcher
- ☐ Office Support
- ☐ Teaching a Class
- ☐ Fundraising/Advisory Committee
- ☐ Cafe Host
- ☐ Helping Hands for Life Circles
  - games & activities, one-on-one interaction with clients.

Any other areas of interest not listed above: _____

_____

_____

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

_____

_____

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 several agencies (listed on Release of Information form). In the event an applicant has been convicted of a crime, the Human Resources 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.

AgeWell Services
275 W. Clay Ave. Suite 100
Muskegon, MI 49440

AgeWell SERVICES
(231) 755-0434
Toll free: 1-800-442-6769
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 account numbers
Address	Phone and fax number	
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.

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.

_____ _____

Signature Date

RELEASE OF INFORMATION

It is the policy of AgeWell Services to conduct a standard background check on each team member and volunteer. AgeWell Services is currently conducting these checks through the Michigan State Police Criminal History Log, Michigan Sex Offender Registry, SAMs and the National Sex Offender Registry. AgeWell Services reserves the right to run additional background checks as required by our funders and is not limited to the list indicated here. These background checks are run prior to working/volunteering with the agency and periodically through the course of association with AgeWell Services as an employee or volunteer.

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 Legal Name: Driver's License Number:

_____ _____

Ethnic Background (for identification purposes only; required by our background check form):

__American Indian __ Asian __Pacific Islander __Black __Hispanic __White __Other

Sex: _____Male _____Female

Date of Birth (MM/DD/YYYY):

_____

Other name(s) you may have been known by (i.e. maiden name): _____

I hereby authorize AgeWell Services to conduct background checks prior to employment/volunteer service and periodically as required by funding mandates.

Signature:_____ Date:_____

AgeWell Services of West Michigan
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