JOL HEALTHCARE
Home Health • Hospice

## Volunteer Application

Name _____

Street Address _____ City, State, Zip _____

Cell Phone _____ Home Phone _____

E-mail Address _____

Preferred method of communication ____email ____home phone ____cell phone ____text

Currently Employed? No ☐ Yes ☐

If Yes, Employer _____

May we call you at work? Yes ☐ No ☐ If Yes, Work Phone: _____

Emergency Contact _____

Relationship _____

Home Phone _____ Cell Phone _____

Foreign Language Proficiency _____

Education ☐High School ☐ Diploma ☐ G.E.D. ☐ Associate's in _____

☐ Bachelor's in _____ ☐ Master's in _____

☐ Other _____

Professional Certifications or Licenses _____

Professional, Community, or Other Organizations _____

_____ _____

Volunteer's Signature Date

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## Volunteer Opportunities

Volunteer Name _____ Date _____

Are you a Veteran? ☐ No ☐ Yes If yes, which branch of service? _____

Please check any and all categories in which you are interested.
All categories require JOL Volunteer training to be completed prior to volunteering.

— **Office Assistance** Volunteers are needed to assist with administrative tasks and projects necessary to the daily functioning of JOL Healthcare. This volunteer opportunity is at the main office. We strive to match volunteer interests and talents to the administrative needs of the organization.

☐ Computer skills ☐ Filing ☐ Making admission packets
☐ Answering calls ☐ Housekeeping ☐ other _____

— **Special and Seasonal Projects** Volunteers will help organize social and seasonal events or trainings for JOL Healthcare staff and volunteers. This may include providing refreshments, door prizes, speakers, etc. for such events, as requested.

— **Patient & Family Care** Assist in meeting the needs of JOL Healthcare patients and families, working with JOL Healthcare staff, as requested by the R.N. Case Manager or other JOL Healthcare staff. May include staying with patient while patient's caregiver leaves to run errands or take a much-needed break, read to the patient or friendly visits.

— **Facility Activities** JOL Healthcare volunteers visit the local nursing homes and assisted care facilities performing a variety of activities with the residents to brighten their days. We have exercise sessions, birthday celebrations, holiday celebrations and BINGO that always need volunteers to assist.

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## Volunteer Opportunities Continued

__ **Hospice Hounds** Volunteers and their Therapy Dog International certified therapy dogs make visits to our patients (in the home, hospital or at skilled nursing facilities), as well as special events. Visiting with animals can help people feel less lonely and/or depressed and can be a welcome change of routine. Pets pay little attention to age or physical ability but accept people as they are. We are excited to launch this program and get our "Hospice Hounds" out in the community.

— **Specialized Services** These volunteer opportunities require a current state license in a specialized field, such as: nail technicians, hairdressers, barbers, and masseuses/masseurs. This is a very generous service opportunity for those with these specialized skills to offer to JOL Healthcare patients in their homes, the hospital or at skilled nursing facilities.

— **Musician** Do you play an instrument? Playing live music is an uplifting way to enhance the lives of JOL Healthcare patients and their families. As Bob Marley once said, "One good thing about music, when it hits you, you feel no pain."

— **Bereavement** There are many after care actions that JOL does for the families of the deceased patient. Assistance in writing bereavement letters and making bereavement follow-up calls is always needed.

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## Volunteer Data Sheet

Volunteer Name _____

**While this information helps in volunteer assignments, no question is mandatory.**

Birth Date _____ Spouse's Name _____

Do you have children at home? _____

The most recent death of someone close was (relationship and circumstances):

_____

_____

What makes you interested in hospice volunteer work? _____

_____

_____

Previous volunteer experience (for what agencies and performing what services):

_____

_____

_____

_____

Do you have special skills, interests, or hobbies you would like to use as a volunteer? _____

_____

_____

_____

_____

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Is there any disability which might affect your choice of volunteer work? _____

Are there any situations in which you would prefer not to be involved as a hospice volunteer? (Such as with certain diseases, ages, etc.) _____

Is any member of your family a hospice employee? If so, who and which hospice _____

Is there any other information about yourself you would like to share? _____

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I realize failure to observe JOL Volunteer Program Guidelines and Policies, including the need for confidentiality of patient and employee information, may result in dismissal as a JOL volunteer. I understand the personal references I provide will be contacted.

_____ _____

Volunteer Signature Date

Interviewer's Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

JOL Healthcare Volunteer Coordinator Date

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## Confidentiality Agreement

JOL Healthcare employees and volunteers will perform services which may require disclosure of confidential and proprietary information (Confidential Information). Confidential Information is information of any kind, nature, or description concerning matters affecting or relating to the employee's or volunteer's services for JOL/or the products, drawings, plans, processes, or other data of the company. Accordingly, to protect JOL Confidential Information, I agree to the following (please initial each):

— I understand the necessity for confidentiality of all information pertaining to JOL patients and their families.

— I agree to keep all proprietary information confidential, both during and after employment or service as a volunteer. Proprietary information is information specific to JOL and not available from public sources.

— I will not disclose or divulge Confidential Information to others unless first authorized to do so in writing by the Compliance Officer of JOL. I will not reproduce Confidential Information for any purpose other than the performance of my duties for JOL.

— I will, upon request or upon termination of my relationship with JOL, deliver to my supervisor any drawings, notes, documents, equipment, and materials received from JOL or originating from my activities with JOL.

_____

Date

_____ _____

Volunteer name (print) Volunteer signature

_____ _____

Volunteer Coordinator name (print) Volunteer Coordinator signature

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## Volunteer Responsibility Sign-Off Sheet

_____

Volunteer Name

- I understand that keeping records is an important part of my volunteer work:
    - Tracking volunteer time
    - Tracking mileage to and from volunteer assignments
    - Patients visit observations
    - Other pertinent data requested by JOL Volunteer Coordinator or staff

- I understand the need to keep all records regarding my volunteer work up-to-date and turned in to Volunteer Coordinator with deadlines.
    - Patient related records **must be** turned in within two (2) weeks of the volunteer assignment.
    - Volunteer time sheet and non-patient related records are due by the 10th of the following month so they may entered into tracking records.

- I have received the Job Description(s) for the volunteer service(s) I intend to fulfill.
- I have received a copy of the JOL Volunteer Handbook.

_____ _____

Volunteer Signature Date

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## Statement of Eligibility/ Criminal Background Check

Volunteer Full Name (exactly as it appears on Driver's License)

Driver's License Number _____ State ID Issued _____

Date of Birth _____ Social Security Number _____

By execution of this document, I acknowledge that I have been informed that a criminal history check will be performed yearly on my name. I understand my ability to perform as a volunteer for JOL Healthcare is pending on the results of the criminal history check.

**I have not been convicted of the following crimes:**

- An offense under Chapter 19, Penal Code (criminal homicide);
- An offense under Chapter 20, Penal Code (kidnapping, false imprisonment);
- An offense under Chapter 21.11, Penal Code (indecency with a child);
- An offense under Chapter 22.011, Penal Code (sexual assault);
- An offense under Chapter 22.02, Penal Code (aggravated assault);
- An offense under Chapter 22.04, Penal Code (injury to a child, elderly individual, or disabled individual);
- An offense under Chapter 22.041, Penal Code (abandoning or endangering a child);
- An offense under Chapter 22.08, Penal Code (aiding suicide);
- An offense under Chapter 25.031, Penal Code (agreement to abduct from custody);
- An offense under Chapter 25.08, Penal Code (sale or purchase of a child);
- An offense under Chapter 28.02, Penal Code (arson);
- An offense under Chapter 29.02, Penal Code (robbery);
- An offense under Chapter 29.03, Penal Code (aggravated robbery);
- An offense under Chapter 31, Penal Code (theft); or
- An offense that the facility determines to be a contraindication to employment with the consumers JOL Healthcare serves.

For Volunteer Personnel

I understand that all information obtained by this agency regarding any criminal or misconduct history will remain confidential. I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

I understand that my name may also be checked through the TX Nurse Aide registry.

_____ _____

Volunteer signature Date

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## Personal Reference Form 1

_____
Volunteer Name

JOL requires volunteers to provide two personal references (not related to the volunteer):

Reference Name:_____

Name _____

Street Address _____ City, State, Zip _____

Cell Phone _____ Home Phone _____

How long have you known this reference?_____

Do not write below this line.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Reference Checked by:_____Date:_____

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## Personal Reference Form 2

_____
Volunteer Name

JOL requires volunteers to provide two personal references (not related to the volunteer):

Reference Name:_____

Name _____

Street Address _____ City, State, Zip _____

Cell Phone _____ Home Phone _____

How long have you known this reference?_____

Do not write below this line.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Reference Checked by:_____Date:_____

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## Volunteer Job Description

**Job Title/Position** Volunteer **Reports To** Volunteer Coordinator

The Volunteer provides patient care and support services according to his/her experience and training and in compliance with organization policies.

**Essential Job Functions/Responsibilities:**

1. Serves as a member of the interdisciplinary group amid various settings: home care, respite, inpatient, bereavement and office duties.
2. Participates in volunteer training and orientation.
3. Serves the patient and family/caregiver under guidance of the Volunteer Coordinator and Case Manager or as a part of the administrative team.
4. Supports the caregiver in the home, performing activities that the volunteer has been prepared for and has agreed to perform. The volunteer may do homemaker chores, run errands, and provide respite care.
5. Provides availability on a regular basis and/or keeping with the patient and family or caregiver needs.
6. Participates in volunteer support groups and/or educational in-services.
7. Maintains open communication and reports regularly to the Volunteer Coordinator.
8. Participates in Quality Assessment Performance Improvement teams and activities.
9. Participates in interdisciplinary group meetings, as appropriate.
10. Maintains patient confidentiality.

11. Completes necessary documentation.
12. Promotes Hospice in the community.
13. Assignment of other duties (as needed) directed by the Volunteer Coordinator.
14. Supports the JOL mission and values.
15. Completes other duties and projects as assigned.

The above statements are intended to be a representative summary of the major duties and responsibilities performed by incumbents of this job.

Volunteer Signature _____ Date _____

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## Volunteer Job Description Continued

**Job Title/Position:** Volunteer

**Position Qualifications**

1. Mature individual, supportive of the hospice concept, comfortable with his/her own spirituality, and willing to serve others in a volunteer capacity.
2. Successful completion of JOL volunteer training and orientation program.
3. Previous volunteer experience may be helpful.
4. Ability to work within the interdisciplinary group.
5. If making home visits, must be a licensed driver with an automobile that is insured in accordance with state or organization requirements and is in good working order.

I have read and understand the requirements and expectations of this job.

Volunteer Signature _____ Date _____

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## Tuberculosis Testing

Volunteers who have face to face contact or potential exposure to TB through shared air or space will be included in the TB testing program. Volunteers who **DO NOT** have face to face patient contact will be exempt from the TB testing program.

**Guidelines:**

Volunteers involved in direct patient care will have a baseline two-step tuberculin skin test completed upon hire and then repeat testing **ONLY** if TB exposure occurs. Annual testing is not required because JOL is a non-traditional facility based setting with a low risk classification, according to CDC guidelines.

**Exemptions:**

1. Those who have had tuberculosis in the past and completed an adequate course of therapy
2. Those presently on effective tuberculosis drug therapy.
3. Those who have had a significant reaction and prolonged documentation of adequate investigation or treatment.
4. Those with an allergy to the purified protein derivative (PPD).
5. Any person who has had a positive skin test and a previous negative chest x-ray for active TB.

New volunteers included in the TB testing program with a skin test completed in the previous 12 months must show verification to the Volunteer Coordinator within 30 days of hire before beginning any volunteer assignment. A copy of the test will be maintained in the TB Testing book located in the Patient Care Coordinator's office as well as the volunteer's file.

The first step of the testing will be administered during volunteer training. A second test will be performed 1-3 weeks after the first test. Volunteers with a positive baseline test result should receive a chest x-ray to exclude a diagnosis of TB. Repeat x-rays are not required unless signs or symptoms of TB develop or after a new exposure to active TB. If the second test is positive the employee/volunteer will be referred to their primary care provider or the health department for further evaluation.

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References:

Centers for Disease Control. (2016) https://www.cdc.gov/tb/education/provider_edmaterials.htm

Texas Department of State Health Services. (2017) https://www.dshs.texas.gov/idcu/disease/tb/

TB Skin Testing - Administration of Tuberculin Purified Protein Derivative (Mantoux)

Volunteer Name _____ Date _____

**Exemptions from testing** (please check which apply):

_____ In the last 12 months I have had a PPD skin test. (If so, provide a copy of the results).

_____ I have an allergic reaction to the PPD skin test.

_____ I have had a positive skin test and had a previous negative chest x-ray for active TB or completed the prescribed course of therapy (Provide documentation of results or therapy).

_____ I am presently on effective tuberculosis drug therapy.

_____ I am presently pregnant and prefer not to take the PPD skin test.

_____ In the past 6 weeks I have taken corticosteroids or immunosuppressant medications.

**TB Two-Step Skin Testing Results – Baseline testing only**

**1st test:** Date skin test administered _____ Given by _____

Date skin test read (within 48-72 hours)_____ Read by _____

Results of the PPD skin test (circle one) NEGATIVE POSITIVE _____ mm

**2nd test:** Date skin test administered: _____ Given by _____

Date skin test read (within 48-72 hours) _____ Read by _____

Results of the PPD skin test (circle one) NEGATIVE POSITIVE _____ mm

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**TB Testing After Exposure to Active TB**

**1st test:** Date skin test administered _____ Given by _____

Date skin test read (within 48-72 hours) _____ Read by _____

Results of the PPD skin test (circle one) NEGATIVE POSITIVE _____ mm

**2nd test:** Date skin test administered _____ Given by _____

Date skin test read (within 48-72 hours) _____ Read by _____

Results of the PPD skin test (circle one) NEGATIVE POSITIVE _____ mm

**Reaction will be determined by CDC guidelines**

References:

Centers for Disease Control. (2016) https://www.cdc.gov/tb/education/provider_edmaterials.htm

Texas Department of State Health Services. (2017) https://www.dshs.texas.gov/idcu/disease/tb/

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## Volunteer Name Badge

Volunteer Name _____ Date _____

Name to appear on badge _____ (please print)

*All volunteer badges will have volunteer title.*

_____ _____

Volunteer Coordinator Date

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## Hepatitis B Vaccine

Please initial all that apply to you:

— I have received a copy of the Hepatitis B Vaccine Information Statement Form 42 U.S.C. § 300aa-26.

— I understand that as a patient care volunteer I may elect to receive this vaccine.

- I will need to take three letters, one each time, at the intervals explained on the information sheet.
- I will see the Volunteer Coordinator prior to each trip to receive the appropriate letter.
- I will bring the documentation of the completed process back to JOL office for my volunteer JOL file.

**Please sign one of the following statements:**

1. **I wish** to receive the vaccine at my own expense, either at my primary care physician's office or the County Health Department, and I will bring documentation of the completed process to JOL.

Volunteer Signature _____ Date _____

2. **I DECLINE** the Hepatitis B Vaccine and understand that this does not limit my ability to be a patient care volunteer.

Volunteer Signature_____ Date _____

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## Volunteer Video/ Photograph Release

I hereby grant JOL the irrevocable right and permission to use photographs and/or videos of me on the JOL website and in JOL publications, JOL marketing and/or promotional literature, JOL training materials, derivative works, or for any other similar purpose without compensation to me.

I understand and agree that such photographs and/or video recordings of me may be placed on the Internet. I also understand and agree that I may be identified by name and/or title in printed, Internet or broadcast information that might accompany the photographs and/or video recordings of me. I waive the right to approve the final product. I agree that all such portraits, pictures, photographs, video and audio recordings, and any reproduction thereof, and all plates, negatives, recording tape and digital files are and shall remain the property of JOL.

I hereby release, acquit and forever discharge the State of Texas, JOL, its current and former trustees, agents, officers and employees of the above-named entities from any and all claims, demands, rights, promises, damages, and liabilities arising out of or in connection with the use or distribution of said photographs and/or video recordings, including but not limited to any claims for invasion of privacy, appropriation of likeness or defamation.

I hereby warrant that I am eighteen (18) years old or more and competent to contract in my own name or, if I am less than eighteen years old, that my parent of guardian has signed this release form below. This release is binding on me and my heirs, assigns and personal representatives.

_____ _____

Signature of Individual Photographed/ Recorded | Date

_____ _____

Printed Name of Individual Photographed/ Recorded | Date

_____ _____

Signature of Witness | Date

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**If individual photographed/recorded is under eighteen (18) years old, the following section must be completed:** I have read and I understand this document. I understand and agree that it is binding on me, my child (named above), our heirs, assigns and personal representatives. I acknowledge that I am eighteen (18) years old or more and that I am parent or guardian of the child named above.

_____ _____

Signature of Parent/ Guardian of Individual Photographed/ Recorded | Date

_____ _____

Printed Name of Parent/ Guardian of Individual Photographed/ Recorded | Date

_____ _____

Signature of Witness | Date

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## Volunteer Application Checklist

Tab 1

- — Copy of Driver's License
  - o Renewal copy received _____
- — Copy of Automobile Insurance
  - o Renewal copy received _____

Tab 2

- — Volunteer Application
- — Volunteer Data Sheet
- — Volunteer Opportunities
- — Personal Reference Form 1 & 2

Tab 3

- — Job Description
- — Confidentiality Agreement
- — State of Eligibility/ Criminal Background Check
- — DPS Computerized Criminal History (CCH) Verification
  - o Date given to JOL Human Resources for processing _____
  - o Date HR approved volunteer for JOL service _____
  - o OIG /EMR Check
- — Volunteer Responsibility Sign-Off Sheet
- — Volunteer Video/ Photograph Release
- — Name Tag

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Tab 4

— Education

— Evaluations

**Medical Binder**

— Tuberculosis Testing

— TB Skin Testing – Administration of Tuberculin PPD

  - Initial test date _____

  - TB two-step date _____

— Hepatitis B Vaccine

— Hepatitis B Vaccine Information Statement

Volunteer Application Checklist Continued

— Volunteer Photo

— Volunteer Training Course Completed _____

— Annual Survey/ Questionnaire
  - Date Received _____

— Annual Volunteer Program Evaluation
  - Date Received _____

— Mandatory Annual CHAP Competency Skills Test
  - Date Received _____

— Annual Infection Control Training
  - Date trained _____

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Notes from Volunteer Services Department:

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DPS Computerized Criminal History (CCH) Verification

I, _____, acknowledge that a Computerized
Applicant Full Name as appears on State/ Government Issued Identification
Criminal History (CCH) check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB identifiers I supply. (This is not a consent form.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name based information is not an exact search and only fingerprint record searches represent true identification to criminal history, therefore the organization conducting the criminal history check is not allowed to discuss with me any criminal history record information obtained using this method. The agency may request that I have a fingerprint search performed to clear any misidentification based on the result if the name and DOB search. Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

In order to complete the process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at www.txdps.state.tx.us */Crime Records/ Review of Personal Criminal History* or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $24.95 to the fingerprinting services company.

(This copy must remain on file by your agency. Required for future DPS Audits.)

_____
Signature of Applicant

_____
Date

_____JOL Healthcare_____
Agency Name (Please print)

_____
Agency Representative (Please print)

_____
Signature of Agency Representative

_____
Date

**Please:**
**Check and initial each available space**

CCH Report Printed:

YES ____ NO ____ ____ Initial

Purpose of CCH: _____

Empl ___ Vol/Contractor ___ ____ Initial

Date Printed: _____ ____ Initial

Destroyed Date: _____ ____ Initial

**Retain in your files**