

**Bent County HealthCare Center  
Adult Volunteer Application**

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

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

RSVP (Retired Senior Volunteer Program) with organization: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relevant Physical Limitations: \_\_\_\_\_

Volunteer Interests: \_\_\_\_\_

\_\_\_\_\_

Preference of Days and Times to Volunteer: \_\_\_\_\_

\_\_\_\_\_

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

TB Immunization: \_\_\_\_\_

\*Volunteers with 4 hours or more/month are required to get a TB test

\_\_\_\_\_  
Volunteer Signature/Date

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Activity Director/Coordinator's Portion: **Background Check Completed** \_\_\_\_\_ (date & initial)

- Review of volunteer application \_\_\_\_\_ (date & initial)
- Review of volunteer policy packet \_\_\_\_\_ (date & initial)
- Tour of facility \_\_\_\_\_ (date & initial)
- Volunteer orientation completed \_\_\_\_\_ (date & initial)
- Introduction to Elder Council President \_\_\_\_\_ (date & initial)

**Bent County HealthCare Center  
Activities Confidentiality Statement**

By my signature below, I certify the following and agree to abide by the facility's policies and procedures/privacy rules regarding confidentiality, release and access to the elders' personal and protected health information. I understand this information includes any information about the elders of this facility regardless of the source of that information (verbal, written or electronic) and this includes both personal as well as any medical/financial information.

I agree to keep all elder information confidential and will not discuss, release or tell any other persons inside or outside of the facility except to authorized staff/persons as consistent with my role as a volunteer of this facility.

I have been informed and understand the limitations of my role as a volunteer of this facility and will not take, read, copy or write down any information from the elders' medical/financial record unless I have been authorized to do so in adherence with applicable HIPAA regulations and facility policies.

I understand this information is protected by Federal and State regulations and laws and that my breach of confidentiality/unauthorized release whether verbal, written, electronic or release of copies may result in sanctions imposed by the facility, which can include warnings, suspensions, termination of my position, civil lawsuits and reporting of the infraction to State and Federal authorities who can impose fines and prison terms.

I understand release of elder protected health information is for the purpose of treatment of the elder. Information can also be released to obtain payment for services provided and for required health care operation or with elder consent. Release will be within the privacy rules/standards and policies and procedures established by this facility, which includes HIPAA (Health Insurance Portability and Accountability Act) standards for my job or role as a volunteer.

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Signature of Volunteer

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Date

**Bent County HealthCare Center**  
**Activity Program Interests**

Please check all the activities you may be interested in assisting with.

**Group Programs:**

- Arts and Crafts
- Exercise Group
- Active Games (Dominoes/Board Games/Cards)
- Birthday Celebrations
- Holiday Parties
- Gardening/Greenhouse
- Outings (Shopping/Concerts/Fishing)
- Bingo
- Reading Groups
- Men's Club
- Lady's Club
- Evening Movies, etc
- Religious Activities

**Independent Choices:**

- Resident Store (Kountry Kupboard)
- Musical Performances
- Newspaper Reading
- Mending
- Pet Therapy

**One-to-One Visits**

- Conventional Visits
- Letter Writing
- Tables Games/Cards
- Outdoor Rides/Walks
- Reading Aloud/Talking Books

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Volunteer Name

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Date

# BACKGROUNDS INTERNATIONAL

5800 W Alameda Avenue, Suite 400, Lakewood, Colorado 80226, Phone (303) 233-3307, Fax (303) 233-1170

## THIRD PARTY RELEASE AND AUTHORIZATION

Backgrounds International is authorized to do a background investigation on me in the course of consideration for possible employment. I voluntarily and knowingly authorize any law enforcement agency, state, county or federal agency, present employer or supervisor, past employer or supervisor, administrator, finance bureau/office, credit bureau, collection agency, college, university or other institution of learning or certification, private business, military branch or the National Personal Records Center, personal reference, and/or other persons, to give records or information they may have concerning my worker's compensation claim history (including claim number, date of injury, type of injury and name of employer), criminal history, motor vehicle history, earnings history, credit history, health, character, and employment records or any other information requested. I voluntarily and knowingly unconditionally release any named or unnamed informant from any and all liability resulting from the furnishing of this information. A photographic or faxed copy of the authorization shall be as valid as the original. \*\*Backgrounds International is only an information provider and does not make the hiring decision.\*\*

### REGULAR INFORMATION (PRINT LEGIBLY IN BLACK INK)

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

Former/Maiden Names: \_\_\_\_\_

Addresses for the last 5 years: (City, State, Zip Only!) mo/yr      mo/yr

\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Drivers' License Number: \_\_\_\_\_ DL State issued in: \_\_\_\_\_

Position for which you are applying: \_\_\_\_\_

### NON-EMPLOYER RELATED INFORMATION (Required by Backgrounds International only and not to be utilized by the prospective employer.)

Date of Birth: \_\_\_\_\_ Sex: (M/F) \_\_\_\_\_ Race: \_\_\_\_\_

*This area to be used only when notarization is required.*

Subscribed and sworn before me,  
on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
My Commission Expires

\*When using an embossed seal, please shade before faxing. \*

I understand the information at the top of this page and also understand that Backgrounds International is not the employer but an investigative firm, not owned or operated by the prospective employer. I further acknowledge that my date of birth, sex, and or race is to be used for outside investigative purposes by Backgrounds International where this search criteria may be required by certain agencies listed in the top paragraph of this form and will not be utilized for the purposes of a hiring decision.

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

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

Prospective Employer: \_\_\_\_\_