Bent County HealthCare Center
Youth Volunteer Application

Name: ____ Birth date:_______________

Address: ________________________________City:________________________ Zip Code: _______________

Phone #: (home) _______________________________________ (cell) ___________________________________

Email Address: ____

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

Activity Director/Coordinatorøs Portion:

- 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 facilityøs policies and procedures/privacy rules regarding confidentiality, release and access to the eldersø 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 eldersø 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.

____ ______________________

Signature of Volunteer 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
_____Menøs Club
_____Ladyøs Club
_____Evening Movies, etcí
_____ 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

____ __________________
Volunteer Name Date

Bent County HealthCare Center
Youth Volunteer Consent Form

I, ______________________________, parent/guardian of ___________________________ hereby give my consent for my son/daughter to participate in the youth volunteer program for Bent County HealthCare Center. I understand that my son/daughter will provide (_____) hours* of service per week and will participate in only the following activities:

____

____

____

____

In the case of an emergency, please contact:

1. Name ___________________________________ Phone # ______________________
   Relationship ______________________________
2. Name ___________________________________ Phone # ______________________
   Relationship ______________________________
3. Name ___________________________________ Phone # ______________________
   Relationship ______________________________

_______________________________________ __________________________________

Signature, Parent/Legal Guardian Date

*Those who volunteer 4 hours or more per month are required to get a TB test.

Revised 6/28/2011