Grace Hospice Volunteer Application Form

***Please fax, email or mail form to Kelsey Tietje* 1510 11th Ave S, Minneapolis, MN 55404.

Fax 612-238-5991, cell: 651-219-0046, email: kltietje@gracehospicecaring.org.

Personal Information

Name _____

Street Address _____ City/State/Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ Preferred method of contact _____

Church Affiliation (Opt) _____ Birthdate _____

Emergency Contact Name & Phone _____

Interests, skills, experience

Role(s) interested in _____

_____

Knowledge or skills you want to develop or demonstrate _____

_____

Occupation (former or present) _____

Do you have previous volunteer experience? If so, what? _____

_____

Do you have experience working with seniors? If so, what? _____

_____

Possible Roles of a Grace Hospice Volunteer:

- **Pet Therapy**
- **11th Hour Volunteer**
- **One on one patient companionship and support**
- **Administrative**
- **Healing Touch**
- **Bereavement Support**

Background Verification

Have you ever been convicted of a felony? ___ Yes ___ No

Have you been charged with neglect, abuse, or assault? ___ Yes ___ No

Do you have any physical limitations or are you under any treatment which might limit your ability to perform certain types of work? ___ Yes ___ No

If yes, please explain _____

_____

Is this volunteer experience for service hours? ___ Yes ____ # of Hours ___ No

For what organization? _____

Times Available (check all that apply)

__Sunday __Monday __Tuesday __Wednesday __Thursday __Friday __Saturday

__Morning

__Afternoon

__Evening

References

Please provide two non-family references that we may contact:

Name _____ Relation to you _____

Address/City/State/Zip _____

Daytime phone _____

Name _____ Relation to you _____

Address/City/State/Zip _____

Daytime phone _____

How did you hear about us?

_____ Augustana Care

_____ Mount Olivet

_____ Friend / Relative

_____ Grace Hospice Website

_____ Other Internet site/name:

_____Church /Church Name /Affiliation:

_____Newspaper/phone book

_____ Other Source:

Confidentiality

As a Grace Hospice volunteer, I the undersigned, recognize that any information and documents I review in the course of meeting my volunteer responsibilities are to remain in the strictest confidence. No information may be released or discussed except as is necessary for fulfillment of my volunteer responsibilities. Sharing of information, documents, and/or photos requires signed releases for approval of Grace Hospice. Failure to comply with the Confidentiality Agreement will result in immediate termination.

Certification

I agree to adhere to the confidentiality policies of Grace Hospice, and I declare my answers to the questions of this application are true. I give Grace Hospice permission to check my references and information provided.

Volunteer signature _____ Date _____

Parent/guardian signature for volunteers under age 18

_____Date _____

Date Received/Processed: _____

AUTHORIZATION TO RELEASE INFORMATION

MINNESOTA BACKGROUND CHECKS

Please print clearly all information

***Indicates Optional Information**

NAME: First, Middle (full), (Maiden), Last:

_____

Date of Birth (month, date and year) _____

*Social Security Number (9 digits)_____-_____-_____

MN Driver's License # or MN State ID #_____

Gender: ____M____F *Race: _____Caucasian _____African American _____Native American

_____Asian _____ Pacific Islander _____Mixed

Current Street Address, Apt. #_____

City, State, Zip Code_____

*Phone Number _____ - _____

Other last names I have used:_____

I authorize the release of any and all information to Grace Hospice in their background verification of my criminal history. The Minnesota Department of Human Services, Licensing Division is authorized to release to Grace Hospice or its agents any personal information about me relative to the conviction, guilty plea, or nolo contender plea of any crime.

I further understand and waive my rights of privacy in this release of information and hold harmless Grace Hospice and its agents from any liability in this background investigation.

I agree that if any misrepresentation has been made by me herein, or the results of such investigation are not satisfactory, any offer of employment made may be withdrawn, or my employment terminated immediately.

This authorization expires one year from this date.

Signature of

***Volunteer*_____*Date:*_____**

Privacy Notice: MINNESOTA DEPARTMENT OF HEALTH LICENSED FACILITIES SUPPLEMENTAL NURSING SERVICES AGENCIES, EDUCATIONAL PROGRAMS, TEMPORARY EMPLOYMENT AGENCIES, PROFESSIONAL SERVICES AGENCIES

BACKGROUND STUDY PRIVACY NOTICE

Because the Minnesota Department of Human Services is requesting that you provide private information about yourself, the Minnesota Government Data Practices Act requires that you be informed of the following:

1. Purpose and intended use of the information: Minnesota Statutes, section 144.057, requires the Minnesota Department of Human Services (DHS) to conduct background studies on individuals who have direct contact with patients and residents in hospitals, boarding care homes, outpatient surgical centers, nursing homes, home care agencies, residential care homes, board and lodging establishments registered to provide supportive or health supervision services, individuals employed by supplemental nursing services agencies, and controlling persons of a supplemental nursing services agency; and all other employees in nursing homes. The background studies are to be completed according to the requirements in Minnesota Statutes, chapter 245C. The information requested will be used to perform a background study of you that will include at least a review of criminal conviction records held by the Minnesota Bureau of Criminal Apprehension and records of substantiated maltreatment of vulnerable adults and children. DHS may also later require you to submit additional information and/or your fingerprints if necessary to complete your background study. For all individuals who are subject to background studies by DHS, the corrections system will report new criminal convictions for disqualifying crimes to DHS. County agencies and the Minnesota Department of Health report substantiated findings of maltreatment of minors and vulnerable adults to DHS.

2. Whether you may refuse or are legally required to provide the information: Minnesota Statutes, chapter 245C, states that the individual who is the subject of a study must provide sufficient information to ensure an accurate background study.

3. Known consequences that may arise from supplying the information: Individuals who have histories with the characteristics identified in Minnesota Statutes, chapter 245C, will be disqualified from positions allowing direct contact with (and, where applicable, access to) persons receiving services. Health-related licensing boards will make a determination whether to

impose disciplinary or corrective action on individuals regulated by health-related licensing boards who have been determined to be responsible for substantiated maltreatment. Individuals who do not have disqualifying characteristics will not be disqualified.

4. Known consequences that will arise from refusing to supply the requested information: Only items identified as "optional" may be left blank. Refusal to provide the information necessary to ensure an accurate and complete background study will result in your disqualification and an order to the agency or facility to remove you from any position allowing direct contact with (and, where applicable, access to) persons receiving services.

5. Identification of other agencies or entities authorized to receive this information: The information you provide will be shared with the Minnesota Bureau of Criminal Apprehension. If DHS has reasonable cause to believe that other agencies may have information pertinent to a disqualification, the information may also be shared with county attorneys, county sheriffs, courts, county agencies, local police, the Federal Bureau of Investigation, the Office of the Attorney General, agencies with criminal record information systems in other states, and juvenile courts. Background study results may be shared with the Minnesota Department of Health, the Minnesota Department of Corrections, the Office of the Attorney General, non-licensed personal care provider organizations, and health-related licensing boards. If you have a disqualifying characteristic, the facility will be told only that you are disqualified and will not be told what caused your disqualification, unless you were disqualified for refusing to cooperate with the background study or for serious and/or recurring maltreatment of a minor or vulnerable adult. The information about you received as part of a background study is classified as private data and, except for the agencies noted, cannot be shared without your consent.