Senior Resource ASSOCIATION

Promoting Independence in our Community

OFFICE USE ONLY
INTAKE DATE : _____
INTAKE STAFF : _____

Volunteer Application

694 14th Street. Vero Beach, FL 32960

(772) 569-0760

VOLUNTEER INTAKE

Please **print** and complete **all** sections.

Name: _____ Birth Date: _____/_____/_____

Social Security Number: _____-_____-_____

Gender: ☐ Male ☐ Female

Preferred Method of Contact: ☐ Phone ☐ E-Mail ☐ Text

Do you have a valid Florida Driver's License? (If yes, please provide a copy) ☐ Yes ☐ No

If yes, do you have up-to-date automobile insurance? (If yes, please provide a copy) ☐ Yes ☐ No

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____ Cell (_____) _____-_____

Email _____

Emergency Contact: _____ Phone: (_____) _____-_____

Relationship: _____

SKILLS and EXPERIENCE

Please list any skills or interests you wish to share with SRA.

_____

_____

Year Round or Seasonal Resident? _____

Days available to volunteer (circle all available): ☐M ☐T ☐W ☐TH ☐F

How did you hear about us? _____

(Ex: Church, Friend/Relative, Employer-sponsored, newspaper, other)

CONFIDENTIAL INFORMATION POLICY

Volunteers associated with the SRA may be privy to confidential information, such as personal, health, financial, strategic or proprietary in nature. It is the responsibility of all Volunteers and persons associated with SRA to protect such information and misusing this information to gain personal or business advantage is prohibited.

Unauthorized use or disclosure of confidential information from a Volunteer will cause Senior Resource Association to decline the individual's Volunteer Services.

VOLUNTEER ACKNOWLEDGEMENT / RECEIPT CONFIDENTAIL INFORMATION

I have received a copy of the Senior Resource Association's (SRA) **Confidential Information Policy** (this document) and have read and agree to abide by the standards set in this policy for the duration of my Volunteer Services or assignment with SRA.

_____ _____

Signature Date

_____

PRINT NAME (Last, First)

Release and Waiver of Liability

Thank you for your Volunteer Services. We greatly appreciate your assistance and commitment to providing activities and services benefiting seniors in our community.

This Release and Waiver of Liability (the "Release") executed on this _____ day of _____ 20_____, by _____ (the "Volunteer") in favor of Senior Resource Association, a non-profit corporation, their directors, officers, employees, and agents.

The Volunteer desires to work as a volunteer for Senior Resource Association and engage in the activities related to being a volunteer (the "Activities").

The Volunteer hereby freely, voluntarily, and without duress executes this Release under the following terms:

Release and Waiver: Volunteer does hereby release and forever discharge and hold harmless Senior Resource Association and it successors and assigns from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise from Volunteer's Activities with Senior Resource Association.
Volunteer understands that this Release discharges Senior Resource Association from any liability or claim that the Volunteer may have against Senior Resource Association with respect to any bodily injury, personal injury, illness, death, or property damage that may result from the Volunteer's Activities with Senior Resource Association.

Volunteer also understands that Senior Resource Association does not assume any responsibility for or obligation to provide financial assistance, including but not limited to medical, health, or disability insurance in the event of injury or illness.
Volunteer hereby release and forever discharge Senior Resource Association from any claim whatsoever which arises or may hereafter arise on account of any first aid, treatment, or service rendered in connection with the Volunteer's Activities with Senior Resource Association.

The Volunteer understands that the Activities includes work that may be hazardous to the Volunteer. Volunteer hereby expressly and specifically assumes the risk of injury or harm in the activities and releases Senior Resource Association from all liability for injury, illness, death, or property damage resulting from the Activities.
The volunteer understands that, except as otherwise agreed to by Senior Resource Association in writing; Senior Resource Association does not carry or maintain health, medical, or disability insurance for any Volunteer.

Each Volunteer is expected and encouraged to obtain his or her own medical or health insurance coverage.

Photographic Release: Volunteer does hereby grant and convey unto Senior Resource Association all rights, title, and interest in any and all photographic images and video or audio recordings made by Senior Resource Association during the Volunteer's Activities with Senior Resource Association

including, but not limited to, any royalties, proceeds, or other benefits derived from such photographs or recordings.

Volunteer expressly agrees that this Release is intended to be as broad and inclusive as permitted by the laws of the State of Florida and that this Release shall be governed by and interpreted in accordance with the laws of the State of Florida. Volunteer agrees that in the event, that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Release which shall continue to be enforceable.
IN WITNESS WHEREOF, Volunteer has executed this release as of the day and year first above written.

_____
Volunteer Name (Print Please)

_____
Volunteer Signature

_____
Today's Date:

Group/Organization (if applicable) _____

If the volunteer is under the age of 18 a parent or legal guardian must sign.

Parent Signature: _____ (if under 18)

In case of emergency, please contact:

Name: _____

Relationship: _____

Address: _____

Phone: _____

Senior Resource
ASSOCIATION

Promoting Independence in our Community

VOLUNTEER
HIPPA, Confidentiality and Non-Disclosure Agreement

As a volunteer, my supervisor has reviewed HIPPA guidelines for upholding the privacy, integrity, accessibility and retention of confidential and private information when supporting the Senior Resource Association (SRA). I understand that I may have access to patient, for SRA purposes, *client* information. I agree not to discuss or share *client* information with anyone, including a SRA employee unless there is a client-employee relationship, resulting from services (directly or indirectly) provided by SRA.

_____(Initial)

I understand that I may have access to other SRA information, such as financial, employee, contractual or competitive in nature.

_____(Initial)

I understand and will comply with state/federal/agency regulations and laws and SRA policies to assure any information I encounter will remain confidential through its use, and only as a necessity to accomplish work and SRA's mission.

_____(Initial)

I will follow all procedures to maintain confidentiality, integrity, accessibility and retention of all

SRA information, including client information, such as:

- Ensure that passwords are not left out in the open
- Ensure that confidential and private information is properly filed and put away
- Ensuring that confidential and private information is not left out in the open or on a desk
- Discussing such information on an as need basis with appropriate parties
- Not engaging in assumptions or gossip

I will report any misuse of SRA information to my immediate supervisor.

_____(Initial)

Name: _____

(Print)

_____ Date:_____

Signature

Senior Resource
ASSOCIATION

Promoting Independence in our Community

SENIOR RESOURCE ASSOCIATION

AGREEMENT WITH VOLUNTEERS

Volunteer Name: _____

1. AGREEMENT to MAINTAIN CONFIDENTIALITY and REPORT

I understand that, as a Meals on Wheels Volunteer, I am required to maintain the confidentiality of clients' personal health information and the conduct of their personal lives. I also understand that I need to report to a Senior Resource Association (SRA) employee of any client situations that are potentially life threatening or indicative of adult abuse. I will also notify SRA of any client requests and/or concerns regarding food products, preparation and/or delivery.

2. AGREEMENT to HOLD HARMLESS

I agree to assume full responsibility for myself and the use of my automobile while making deliveries on behalf of the program and further agree to hold SRA harmless and without liability in any claim or cause of action arising out of my service as a volunteer. I agree to carry public liability and property damage insurance on my automobile and will provide a copy of insurance and driver's license to SRA. Any changes in your driving record must be reported to SRA immediately.

3. AGREEMENT to COMPLY with FOOD SAFETY and SANITATION GUIDELINES

I agree to keep the cold foods in the cold container and the hot foods in the hot container until I have safely delivered the packaged food into the client's home. I also agree to wash my hands or sanitize hands before opening any containers for a client needing my assistance.

4. AGREEMENT REGARDING TIPS, GIFTS & SOLICITING

I agree not to accept tips or gifts from clients, their families or friends. You may not promote or solicit your own business, enterprise, political agency or religious beliefs while volunteering. On occasion client may give Meals on Wheels donations in an envelope. If the client gives you an envelope please return to the SRA office after your route is completed.

Signature: _____ Date:_____

Thank you for agreeing to serve our community by delivering nutritious food to people unable to cook or shop for themselves. Donating your time and your transportation is truly appreciated

Senior Resource
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Original Date: 8/11/2010 Revision#: Original

Revision Date: **Owner: Human Resources**

Approved: 8/1/2010

Background Screening Policy

The Senior Resource Association must adhere to Florida State Statute 435.04 which requires all individuals who have face-to-face contact with seniors to meet the Level2 screening standards.

Individuals are direct service providers representing the organization either as employees or Volunteers.

These screenings are conducted by a third party company, Live Scan Vendor, and will include verification of information provided on the completed application or on other forms used in the selection/hiring process. The background check includes a search of the FBI Database, The National Sex Offender Registry, The National Criminal History and/or the Florida Dept. of Law Enforcement Databases.

These checks may also include criminal court record searches and/or other data bases as dictated by state statute. All individuals are asked to sign a release form(s) authorizing the appropriate background screenings.

Prior to the screening, individuals are also informed of their right to a) list any potential disqualifying offenses under the Florida State Statute and b) request a copy of their criminal record in the event they are deemed to be disqualified or ineligible. In addition, all individuals are furnished with the contact information of the screening provider as required by law.

Lf a disqualifying result comes back fora Senior Resource employee or volunteer Senior Resource
Association is required to follow the Department of Elder Affairs procedure in this regard.

Once a final disposition is made on any individual, all documentation is retained as appropriate for a period of seven (7) years.

I, , authorize the Human Resource Department of the Senior Resource Association (SRA) and/or designee to perform a background verification. I understand that I will be required to undergo a Level II background check which will be conducted through the Federal Bureau of Investigation (FBI). The background check will ensure that no persons subject to the provisions of the State Law have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under any of the attached provisions of the Florida Statutes or under any similar statute of another jurisdiction

I, understand that my employment or continuation of my employment or Volunteer Service depends on the results of the background verification and that I am also required to inform SRA immediately if convicted of any of the disqualifying offenses while employed. I further understand that all level II screening requests will be reviewed by the Agency for Health Care Administration and that all final determinations will be made by them.

Any individual disqualified from employment due to their background screening that is seeking Exemption from Disqualification must submit the appropriate application to the agency that reviewed the screening results. I further agree to hold harmless the Senior Resource Association (SRA) and its employees from any consequences as a result of obtaining this information.

Signature Date

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

Department of
ELDER AFFAIRS
STATE OF FLORIDA

BACKGROUND SCREENING

Affidavit of Compliance -Employee

AUTHORITY: This form is required of all employees who are direct service providers when claiming an exception to Level 2 background screening set forth in sections 430.0402(2) and (3}, Florida Statutes, or to comply with the attestation requirements set forth in section 435.05(2), Florida Statutes.

This form may be used by **all employees** to comply with:

The attestation requirement of **section 435.05(2), Florida Statutes,** which states that "every employee required to undergo Level2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer;" **AND**

The proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes,** which requires proof of compliance with Level2 screening standards that have been screened through the *Care Provider Background Screening Clearinghouse* created under **section 435.12, Florida Statutes,** or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing Care retirement community under **Chapter 651,Florida Statutes,** if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an application for a health care provider license, please attach a copy of the screening results and submit the licensure application.

The term "employee" as used herein refers collectively to a*ll persons* required by law to undergo background **screening. This includes, but is not limited to, persons who are determined to be a direct service provider. A direct service provider is a person at least 18 years of age who, pursuant to a program to provide services to the elderly, has direct face-to-face contact with a client while providing services and has access to the client's living areas,** funds, personal property, *or* personal identification information as defined in F.S. 817.568, Florida Statutes. A **direct service provider also includes coordinators, managers, and supervisors of residential facilities and volunteers.**

Personal identification information defined in F.S. 817.568(1)(1), F.S. means "any name or numberthat may be used, alone or in conjunction with any other information, to identify a specific individual, including any:

1. Name, postal or electronic mail address, telephone number, social security number, date of birth, mother's maiden name, official state-issued or United States-issued driver's license or identification number, alien registration number, government passport number, employer or taxpayer identification number, Medicaid, or food assistance account number, bank account number, credit or debit card number, or personal identification number or code assigned to the holder of a debit card by the issuer to permit authorized electronic use of such card;
2. Unique biometric data, such as fingerprint, voice print, retina or iris image, or other unique Physical representation;
3. Unique electronic identification number, address, or routing code;
4. Medical records;
5. Telecommunication identifying information or access device; or
6. Other number or information that can be used to access a person's financial resources."

EMPLOYER: IFAN EMPLOYEE IS DETERMINED TO BEA DIRECT SERVICE PROVIDER THIS COMPLETED FORM MUST BE RETAINED INTHE EMPLOYEE'S FILE. IFAN EXCEPTION TO BACKGROUND SCREENING IS CLAIMED A COPYOFTHE REQUIRED EVIDENCE MUST BEATTACHED TOTHIS FORM.

STEP ONE: Complete identification information.

Employee Name

Position Applied For

Employer

☐ I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA)

Date of Decision: _____

☐ I have been granted an Exemption from Disqualification through the Florida Department of Health.

Date of Decision: _____

****A copy of the Exemption from Disqualification decision letter must be attached****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) **in** the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: _____

Screening Conducted by: _____ Date of Prior Screening: _____

☐ Agency for Healthcare Administration

☐ Department of Elder Affairs

☐ Department of Health

☐ Department of Financial Services

☐ Agency for Persons with Disabilities

☐ Department of Children and Family Services

STEP FOUR: Each employee determined to be a direct service provider must complete the required attestation below.

Claiming an Exception: If you are claiming that you qualify for an exception to level 2 background screening, you are not required to undergo background screening through the Department, and you must sign the attestation below.

Not Claiming an Exception: If you are *not* claiming one of the exceptions to level 2 background screening listed in Step Three, you must complete level 2 background screening through the Department. Once you have been determined qualified for service by the Department, you must sign the attestation below.

ATTESTATION

Under penalty of perjury, **I** ,hereby swear or affirm that **I** meet the requirements for qualifying for employment pursuant to the background screening standards set forth in Chapter 435 and section 430.0402, Florida Statutes. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by my employer.

Employee Signature

Date

EMPLOYER: **ONCE THE ATTESTATION IS SIGNED, KEEP THIS COMPLETED FORM IN THE EMPLOYEE'S FILE.**