Volunteer Health Care Provider Program
110 Volunteer Application Checklist

- ☑ Application- With signature on 2nd page
- ☑ 2 Completed Volunteer Personal Reference Questionnaires
- ☑ Volunteer Services Job Description
- ☑ Completed HIPAA Test

Return the completed documents to your Regional Coordinator prior to the date of training, or by email after training. You may keep copies if you desire.

You cannot complete and sign the Eligibility and Referral Forms until you have been trained and a complete application packet is on file.

If you have questions, contact

Lori Thompson
Volunteer Health Services
200 San Sebastian View
St. Augustine, FL 32084
904-588-8307 Phone
Lorraine.Thompson2@FLHealth.gov

VOLUNTEER ENROLLMENT APPLICATION

Name (Last) (First) (Middle)

Mailing Address City State Zip

Work Telephone / Home Telephone / Cell Phone

Email: _____

Emergency Contact Telephone Number

What type of volunteer position are you interested in? Eligibility and Referral Specialist

List any professional license, registration, or certificate you currently possess (include certificate/license number): _____

List any special skills, interests, or hobbies: _____

List any special considerations or needs: _____

List two personal references not related to you whom you have known for more than one year:

NAME
ADDRESS
CITY/STATE ZIP
PHONE

NAME
ADDRESS
CITY/STATE ZIP
PHONE

List your most recent volunteer or employment experience:

EMPLOYER COMPLETE MAILING ADDRESS TELEPHONE

JOB TITLE DATES OF VOLUNTEER/EMPLOYMENT

Specify the days and time frames you are available to volunteer: _____

Day of Week	Hours	Day of Week	Hours
Sunday		Thursday	
Monday		Friday	
Tuesday		Saturday	
Wednesday			

Have you ever been convicted of or plead nolo contendere to a driving or criminal offense?
Yes _____ No _____ If answer is yes, please explain (including types of offenses and dates):

It shall be a misdemeanor of the first degree to fail to disclose, by false statement, misrepresentation, impersonations or other fraudulent means, any material fact used in making a determination as to a person's qualifications to work as a volunteer.

I understand that, to protect persons served by the department, a routine check through law enforcement, license bureaus, agency files, and references may be made. I understand that a criminal offense will not automatically exclude me from all volunteer positions; however, certain convictions will exclude me from volunteering in some positions. I understand that if I answered no to the criminal offense question on the front of this application and a record should be obtained, it will prevent me from volunteering for the department regardless of the offense. I understand upon submission of this application it becomes public record.

I understand and agree that all information as it relates to persons served by the department is to be held confidential in compliance with Florida Statutes. All information that should come to my attention and knowledge as privileged and confidential will not be disclosed to anyone other than authorized personnel and that I shall conduct myself in accordance with the departmental security policies. I understand that failure to comply may result in criminal prosecution.

I affirm that all information on this application is true and correct.

_____ ____/____/____

Signature Date

INTERVIEWER'S COMMENTS
(For Agency Use Only)

Date of Interview: ___/___/____ **Interviewer's Name:** Lori Thompson

Briefed on duties and responsibilities of position. Explained Sovereign Immunity,

Discussed HIPAA requirements and confidentiality.

Trained regarding completion of Eligibility and Referral forms.

Screening Required: Yes _____ **No** ___X___ **Date Screening Completed:** _____

Date Orientation Completed: _____

WORK ASSIGNMENT
(For Agency Use Only)

VHCPP — **Program**

EMMANUEL PROJECT — **Location**

Lori Thompson — **Supervisor**

_____ — **Date of Placement**

It is unlawful for an employer to refuse or deprive any individual of volunteer opportunities because of race, color, religion, sex, national origin, age, marital status, or handicap. Applicants who believe they have been discriminated against may file a complaint with the Florida Commission on Human Relations, 2009 Apalachee Parkway, Suite 100, Tallahassee, Florida 32301-4857.

Volunteer Personal Reference Questionnaire

Name of Volunteer/Intern Applicant _____ Date Completed _____

As required by section 110.503, Florida Statutes and section 60L-33.006, Florida Administrative Code, reference checks must be completed for the above applicant. This applicant wishes to provide volunteer services to clients of the Department of Health. Your name has been given as a personal reference, and we would appreciate your comments on the following questions:

1. How long have you known the volunteer applicant? _____
2. To your knowledge, has the applicant ever been convicted of a crime? _____
3. Do you consider him/her to be of good moral character? If no, please explain. _____
   _____
4. Do you know of any reason why the applicant should not be trusted with or around children or persons with disabilities? _____ If yes, please explain: _____
   _____
5. Would you consider placing the responsibility of a child or a person with disabilities who is related to you with the applicant? _____
6. Do you have any additional comments concerning the applicant's character or reliability? _____
   _____
7. What is your relationship to the applicant? _____

_____ _____
Reference Signature Name (please print)

_____ _____
Address Telephone

_____
City State Zip

Thank you for your time.

Upon completion, please return this form to: The Volunteer Coordinator in your application packet.

Volunteer Personal Reference Questionnaire

Name of Volunteer/Intern Applicant _____ Date Completed _____

As required by section 110.503, Florida Statutes and section 60L-33.006, Florida Administrative Code, reference checks must be completed for the above applicant. This applicant wishes to provide volunteer services to clients of the Department of Health. Your name has been given as a personal reference, and we would appreciate your comments on the following questions:

4. How long have you known the volunteer applicant? _____

5. To your knowledge, has the applicant ever been convicted of a crime? _____

6. Do you consider him/her to be of good moral character? If no, please explain. _____
_____

8. Do you know of any reason why the applicant should not be trusted with or around children or persons with disabilities? _____ If yes, please explain: _____
_____

9. Would you consider placing the responsibility of a child or a person with disabilities who is related to you with the applicant? _____

10. Do you have any additional comments concerning the applicant's character or reliability? _____
_____

11. What is your relationship to the applicant? _____

_____ _____
Reference Signature Name (please print)

_____ _____
Address Telephone

_____
City State Zip

Thank you for your time.

Upon completion, please return this form to: The Volunteer Coordinator in your application packet.

VOLUNTEER POSITION DESCRIPTION

To be completed by requesting program, facility, or CHD/CMS volunteer coordinator.

DATE: _____ SUPERVISOR: Lori Thompson, Volunteer Coordinator

POSITION TITLE: Eligibility & Referral Specialist

LOCATION OF POSITION: EMMANUEL PROJECT

TIME COMMITMENT: as needed

DURATION OF POSITION: Indefinite

DUTIES: Screen patients, determine financial eligibility for DOH, explain sovereign immunity, initiate referrals, insure referrals are completed properly with appropriate signatures, and dates. Maintain and file eligibility and referral forms in the patient's medical/dental records.

QUALIFICATIONS: Read, write and understand the English language. Possess the ability to relate to clients and their needs.

TRAINING: Briefed by the Regional Volunteer Health Services Coordinator on responsibilities and requirements of the position.

WILL THIS POSITION REQUIRE BACKGROUND SCREENING? YES _____ NO X

Lori Thompson — CONTACT PERSON

904-588-8307 — TELEPHONE NUMBER

Volunteer Health Services Program
PROGRAM/FACILTY

200 San Sebastian View, St. Augustine, FL 32084
ADDRESS CITY STATE ZIP

DH 1493, 10/05

One copy of this form remains with the application packet – keep a copy if desired

HIPAA Privacy Quiz

1. True False The HIPAA Privacy Rule protects a patient's fundamental rights to privacy and confidentiality.
2. True False You are called a covered entity if you are a healthcare provider, health plan, and healthcare clearinghouse who transmits health information in electronic form.
3. True False Protected Health Information is anything that connects a patient to his or her health information.
4. True False PHI includes all health information that is used/disclosed – except PHI in oral form.
5. True False PHI is used when it is shared, examined, applied or analyzed.
6. True False PHI is disclosed when it is released, transferred, or allowed to be accessed or divulged outside the covered entity.
7. True False You are permitted to use/disclose PHI for treatment, payment, and health-Care operations.
8. True False You are required to use/disclose PHI when authorized or requested by the individual patient.
9. True False Using PHI for purpose not specified by the rules requires covered entities to get patient authorization.
10. True False Authorization must be obtained for any use/disclosure of PHI for marketing purposes.
11. True False An Authorization must contain an expiration date.
12. True False After signing an authorization, the patient can decide to revoke it.
13. True False You must obtain patient agreement to use/disclose PHI for public health activities related to disease prevention.
14. True False You can use/disclose PHI without patient agreement to report victims of abuse, neglect or domestic violence.
15. True False In general, disclosure of PHI must be limited to the least amount needed to get the job done right.
16. True False The Notice of Privacy Practices gives patients notice about the use/disclo-sure of their PHI, as well as their rights in general.
17. True False The Privacy Rules gives patients the right to request a history of routine disclosures.
18. True False The Privacy Rule gives patients the right to take action if their privacy is violated.
19. True False If you need help understanding the rules, the Department of Health and Human Services is required to give you assistance.
20. True False To protect patient confidentially, learn about your facility's patient privacy rights- and encourage others to do the same.
21. True False Use of PHI is allowable for reasons of treatment, payment or operations (TPO)

Please Print the Following Information

VOLUNTEER NAME _____ **DATE:**_____

AGENCY: **EMMANUEL PROJECT**

HIPAA: PRIVACY COMPLIANCE
Answers to HIPAA Quiz

1. True
2. True
3. True
4. False – PHI includes all health or patient information in any form whether oral or recorded, on paper, or sent electronically.
5. True – PHI is used when shared, examined, applied, or analyzed by a covered entity that receives or maintains it.
6. True - PHI is disclosed when released, transferred, allowed to be accessed, or divulged outside the facility.
7. True
8. True
9. True
10. True
11. True
12. True
13. False – You can use/disclose PHI without patient agreement for public health activities related to disease control and prevention.
14. True
15. True
16. True
17. False – The Privacy Rule gives patients the right to request a history of non-routine disclosures of their PHI.
18. True
19. True
20. True
21. True