Volunteer Ombudsman Application

NAME _____ DATE _____

ADDRESS _____

CITY _____ ZIP CODE _____

EMAIL _____ DATE OF BIRTH _____

HOME PHONE _____ CELL PHONE _____ FAX _____

1. HOW DID YOU FIRST LEARN ABOUT VOLUNTEERING WITH THE OMBUDSMAN PROGRAM?

   _____

2. WHY ARE YOU INTERESTED IN JOINING THE PROGRAM? _____

   _____

   _____

3. ARE YOU PRESENTLY EMPLOYED? ☐ YES ☐ NO

IF YES, WHERE ARE YOU EMPLOYED? _____

4. HAVE YOU SPENT TIME (AS A VISITOR, EMPLOYEE, VOLUNTEER, OR ANY OTHER ROLE) IN NURSING FACILITIES, RESIDENTIAL CARE FACILITIES, OR ASSISTED LIVING FACILITIES?
☐ YES ☐ NO

NAME OF FACILITIES DATES YOU ROLE

_____

_____

_____

PLEASE DESCRIBE YOUR EXPERIENCES: _____

_____

_____

_____

5. THIS PROGRAM REQUIRES VISITING A LONG-TERM CARE FACILITY AT LEAST 1-2 TIMES A MONTH AND A COMMITMENT OF ABOUT 3-4 HOURS A WEEK ON ADVOCACY EFFORTS. CAN YOU MEET THIS REQUIREMENT? ☐ YES ☐ NO

6. ARE YOU WILLING AND ABLE TO MAKE A ONE-YEAR COMMITMENT TO VOLUNTEER WITH THE OMBUDSMAN PROGRAM? ☐ YES ☐ NO

7. THIS VOLUNTEER POSITION REQUIRES WORKING WITH VULNERABLE ADULTS. A CRIMINAL BACKGROUND CHECK IS REQUIRED ON ALL VOLUNTEERS FOR STATE CERTIFICATION. HAVE YOU EVER BEEN CONVICTED OF A CRIME? ☐ YES ☐ NO

8. LIST ALL PREVIOUS VOLUNTEER EXPERIENCE. PLEASE INCLUDE THE ORGANIZATION, YOUR INVOLVEMENT, AND THE LENGTH OF TIME YOU VOLUNTEERED:

_____

_____

_____

9. DO YOU OWN OR ARE YOU EMPLOYED BY A SKILLED NURSING FACILITY, A RESIDENTIAL CARE FACILITY, AN INTERMEDIATE CARE FACILITY, OR AN ADULT DAY HEALTH CARE FACILITY?
☐ YES ☐ NO

10. ARE YOU RELATED, DIRECTLY OR BY MARRIAGE, TO ANYONE WHO OWNS OR IS EMPLOYED BY ANY OF THE ABOVE-NAMED TYPES OF LONG TERM CARE FACILITIES? ☐ YES ☐ NO
IF YES, IS THIS FACILITY IN MONTEREY COUNTY? ☐ YES ☐ NO

11. DO YOU CURRENTLY WORK AS A VOLUNTEER IN ANY OF THE ABOVE-NAMED TYPES OF LONG-TERM CARE FACILITIES? ☐ YES ☐ NO
IF YES, WHICH FACILITY? _____

12. DO YOU THINK THERE IS ANY OTHER FACTOR, WHICH MIGHT CONSTITUTE A POTENTIAL CONFLICT OF INTEREST FOR YOU AS AN OMBUDSMAN? ☐ YES ☐ NO

IF YES, PLEASE ELABORATE: _____

_____

_____

❖References❖

13. PLEASE IDENTIFY TWO REFERENCES INCLUDING AT LEAST ONE EMPLOYMENT REFERENCE, IF POSSIBLE. NO RELATIVES, PLEASE.

NAME	RELATIONSHIP	PHONE

❖Emergency Contact Information❖

In the event that you become a certified volunteer representative, we will need to know who we should notify in the event of an emergency.

Name _____

Relationship to you _____ Phone Number _____

Address _____

❖Volunteer Assurances❖

As a volunteer Ombudsman, I understand that the program requires a commitment to the ideals of the program that have been explained to me and I provide assurances that I will comply with these ideals as stated below:

I am at least 21 years old. ☐ YES ☐ NO

I have reliable transportation. ☐ YES ☐ NO

I agree to be tactful, diplomatic and non-judgmental. ☐ YES ☐ NO

I will be reliable and conscientious. ☐ YES ☐ NO

I agree to be respectful of residents' preferences and cultural views. ☐ YES ☐ NO

I will listen objectively without inserting my personal values when listening to residents. ☐ YES ☐ NO

I have no family/friends residing in a facility in which I volunteer. ☐ YES ☐ NO

I agree to participate in a criminal background check. ☐ YES ☐ NO

I understand that the work I do is confidential. I will not share any information about complaints, records, facilities, residents, or staff with anyone outside the Ombudsman program. ☐ YES ☐ NO

I agree not to express an opinion about the quality of specific long-term care facilities to the public, family, or friends. ☐ YES ☐ NO

I agree to complete the paperwork in a timely manner as identified by my supervisor. ☐ YES ☐ NO

I do not have financial, personal, or professional conflict with long-term care facilities. ☐ YES ☐ NO

_____ _____

Name Date