Companion Care Volunteer Paperwork Checklist

NAME ______________________ DATE ____________

FORM	REQUESTED	RECEIVED
• General Application	________	________
• Personal Statement of Health	________	________
• Proof of Covid-19 Vaccination	________	________
• Consent of Drug Test	________	________
• AHCA Forms	________	________
• Fingerprint Questionnaire (Background)	________	________
• Confidentiality Agreement (HIPPA)	________	________
• Volunteer Commitment Agreement	________	________
• Driver License & Insurance Card	____ ____	____ ____
• References	________	____ ____
• Conflict of Interest / **Privacy Release Statement**	________	________
• Job Description	________	________
• Volunteer Training Competency	________	________
• Corporate Compliance Plan	________	________
• Sexual/Child Abuse Policy	________	________
• Volunteer Training Class Test	________	________
• Alzheimer Information Sheet	________	________
○ Alzheimer 1 Hour Training	________	________
○ Alzheimer 3 Hour Self-Study	________	________
• Hand Hygiene	________	________
• Infection Control Program	________	________
• Fire Safety / Emergency Disaster Plan	________	________
• Volunteer Yearly Review	________	________

I.D. NUMBER: ______________

ALL PAPERWORK IS IN FILE AS OF: ____________ (Date) ________________ (Signature)

Volunteer Application

☐ Companion Care ☐ We Honor Veterans

☐ Administrative ☐ Pet Peace of Mind

Personal Information Name (Last, First, MI)	Are you over 18 years of age? ☐ Yes ☐ No
Address (Street, City, State, Zip)	Preferred Phone No.
Email Address	Best time to reach you

Are you a Seasonal Resident? ☐ Yes ☐ No If yes, provide seasonal resident dates:

Are you a Veteran? ☐ Yes ☐ No If yes, what branch? ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marines ☐ Navy

Fingerprint Questionnaire: *(Below information required to register you for background screening)*

Date of Birth:	Place of Birth:
Country of Citizenship:	Social Security:
Gender:	Ethnicity:
Eye Color:	Hair Color:
Height:	Weight:

General Information:

Have you ever worked or volunteered for Catholic Hospice before? ☐ Yes ☐ No If yes, details:

What is your availability to volunteer?
☐ Weekly______hrs ☐ Bi-Weekly______hrs ☐ Monthly______hrs ☐ Other______________

How many miles are you willing to drive for a volunteer assignment?

Please describe any previous education or experiences you've had that would be helpful in volunteering.

Date	Education, Volunteer Experience, and/or Work History

How did you learn about Catholic Hospice, Inc.?

Why do you want to be a Catholic Hospice volunteer?

What strengths and special skills do you bring to Catholic Hospice?

Have you had experience with the elderly or terminally ill people?

Do you speak any foreign language? ☐ Yes ☐ No If so, which language?

General Information (cont'd):

Have you ever been convicted of a felony? ☐ Yes ☐ No If yes, please describe the offense, the date of the conviction and the underlying circumstances or other information to help us evaluate your current fitness to become a volunteer.

Are you willing to: *(Please check areas of interest)*

- ☐ Assist patients with preparations/shopping before/after a hurricane.
- ☐ Visit patients at nursing homes/assisted living facilities
- ☐ Accept an assignment in a home with pets?
- ☐ Accept an assignment in a home with smokers?

Areas of Interest: *(Please check areas of interest.)*

Patient Related Services

- ☐ Caregiver Relief
- ☐ Friendly Visits
- ☐ Write Letters
- ☐ Shopping/Errands
- ☐ Veteran Pinning Ceremony
- ☐ Pet Visits
- ☐ Bereavement
- ☐ Phone Calls
- ☐ Home Chores

Areas of Interest: *(Please check areas of interest.)*

Non-Direct Patient Related Services

- ☐ Office Work
- ☐ Mass Mailings
- ☐ Sewing/Crafts
- ☐ Community Events
- ☐ Other: ____________________

Required Documentation: *(Please provide copy of documentation listed below)*

Driver's License	Car Insurance	Covid-19 Vaccination Card

Emergency Contacts: *(Please provide one (1) person to contact in case of emergency)*

Name	Relationship
Home Phone	Cell Phone

Professional References: *(Please provide information of two (2) professional reference)*

Name	Relationship
Home Phone	Cell Phone
Name	Relationship
Home Phone	Cell Phone

I HEREBY CERTIFY THAT THE INFORMATION STATED ABOVE IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: ______________________________ DATE: ______________________________

Personal Statement of Health

I, ______________________ hereby state that, to the best of my knowledge, I am in good health
(Name of volunteer)

and free from communicable disease.

☐ I will be taking the Mantoux test for tuberculosis during training class.

☐ I will not be taking the Mantoux test for tuberculosis, but I will be

Submitting a copy of the results of ☐ my recent chest x-ray

☐ A previous TB test taken recently

______________________ ______________________

(Volunteer's Signature) (Date)

Declaración Personal de Salud

Yo, ______________________, confirmo que a mi entender, estoy en buena salud y libre de enfermedades

contagiosas.

☐ Voy a tomar la prueba Mantoux para tuberculosis durante la clase de entrenamiento.

☐ No voy a tomar la prueba Mantoux, pero voy a entregar una copia de los resultados de

☐ mi radiografía del pecho tomado dentro del año

☐ mi prueba Mantoux tomada dentro del año

______________________ ______________________

(Firma del voluntario) (Fecha)

CONSENT FOR DRUG TEST SCREEN

Recognizing that substance abuse (including alcohol) is a detrimental problem facing society, Catholic Hospice Inc (CHI) is committed to providing a drug-free workplace for all employees and volunteers.

CHI understands employees and applicants under a physician's care may be required to use prescription drugs; however, illegal use of prescribed medications is also substance abuse and will be dealt with in the same manner as the abuse of illegal substances. The goal of this policy is to balance our respect for individual privacy with our need to keep a safe, productive, drug free environment.

As a job applicant, I freely and voluntarily agree to a urinalysis drug screen as part of my application for employment and I understand that a refusal to test, a positive confirmed drug test or a tampered with or an adulterated specimen will disqualify me from employment, even if I have started work pending the results of the drug test. I understand I am still completing the application process and will not officially be an employee until the company receives a negative pre-employment drug test result. If I am employed by Catholic Hospice Inc., I understand and agree to abide by the company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, as stated above.

______________________________ ____________________________

Applicant's Signature Date

____

Name (Print)

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

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

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

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 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 level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., 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, F.S., and in accordance with the standards in Section 408.809(2), F.S., 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 with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **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 Health
- ☐ Agency for Persons with Disabilities
- ☐ Department of Elder Affairs
- ☐ Department of Financial Services
- ☐ Department of Children and Family Services

Attestation

Under penalty of perjury, I, ______________________________, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

______________________________	____________________	______________
Employee/Contractor Signature	Title	Date

CONFIDENTIALITY AGREEMENT

This Agreement is made between Catholic Hospice Inc, (CHI) and applicant/volunteer
____(called "you").

You are employed by Catholic Hospice Inc. (CHI). In both your training, and in doing the job, you encounter confidential information that CHI needs to protect.

"Confidential Information" is any information of any kind, nature, or description concerning any matters affecting or relating to your services for CHI, the business, or operations of CHI, and/or the service products, processes, or other any other data of CHI. Accordingly, to protect the CHI Confidential Information that will be disclosed to you, you agree as follows:

1. You will hold the Confidential Information in strict confidence and shall exercise a reasonable degree of care to prevent disclosure to others.
2. You will not disclose or divulge either directly or indirectly the Confidential Information to others unless first authorized to do so in writing by CHI's Compliance Officer
3. You will not reproduce the Confidential Information nor use this information commercially or for any purpose other than the performance your duties for CHI.
4. You will, upon the request or upon termination of your relationship with CHI, deliver to CHI any notes, documents, equipment, and materials received from CHI or originating from your activities for CHI.

CHI reserves the right to take disciplinary action, up to and including termination for violations of this agreement.

Signing below signifies that the VOLUNTEER agrees to the terms and conditions of the agreement stated above.

CH Volunteer Manager / Volunteer Coordinator	NAME (VOLUNTEER)
____________________	____________________
Manager's Signature	Volunteer's Signature
____________________	____________________
Date: ____________________	Date: ____________________

Volunteer Commitment

I agree to serve as a volunteer with Catholic Hospice, Inc.

I understand that as a volunteer, the following are expected of me:

1. Regular attendance at meetings when requested (team meetings, support groups, continuing
   education and bereavement team meetings.
2. Reliability when assigned to patient/families, office tasks, and other volunteer projects.
3. Commit to volunteering a minimum of 5 hours per week
4. Accurate and up-to-date record keeping and charting.
5. Advance notice or resignation from this program and participation in an exit interview.

As a Catholic Hospice volunteer, I will respect the confidentiality of all information gained in the course of my work. I will also allow each patient/family the freedom to define the type of care they wish to receive.

In return for volunteer work, I will receive from the staff of Catholic Hospice, team training, continuing education, and on-going support. I will receive supervision encouragement, evaluation, and recognition from the Volunteer Manager/Coordinator.

____

Volunteer Date

____

Volunteer Services Manager/Coordinator Date

A copy of your driver's license for the State of Florida and a copy of your current auto insurance card must be included with this application packet.

☐ Florida Driver's license included or ID card

☐ Auto Insurance card included

VOLUNTEER REFERENCE INQUIRY

Applicant Name: ___________________________

Position Applied For: _______________________

Date: ____________________________________

To: ____

Phone Number: ______________________________

The above-named applicant has given your name as a reference. We would appreciate very much if you would give us your answers to the following questions. Please be assured that all information will be held in strict confidence.

The Applicant's	High	Average	Fair	Poor
Integrity	[ ]	[ ]	[ ]	[ ]
Neatness	[ ]	[ ]	[ ]	[ ]
Conscientiousness	[ ]	[ ]	[ ]	[ ]
Cooperation	[ ]	[ ]	[ ]	[ ]
Punctuality	[ ]	[ ]	[ ]	[ ]

Length of time you've known applicant: ____

Other remarks: ____

____

____

____ ______________________

Manager/Volunteer Coordinator Signature Date

VOLUNTEER REFERENCE INQUIRY

Applicant Name: ______________________

Position Applied For: ____________________

Date: ______________________________

To: ____

Phone Number: __________________________

The above named applicant has given your name as a reference. We would appreciate very much if you would give us your answers to the following questions. Please be assured that all information will be held in strict confidence.

The Applicant's	High	Average	Fair	Poor
Integrity				
Neatness				
Conscientiousness				
Cooperation				
Punctuality				

Length of time you've known applicant: ________________________________

Other remarks: ____

____

____

___________________________________ ____________________

Manager/Volunteer Coordinator Signature Date

Resolution and Disclosure Regarding Conflict of Interest

Whereas, Catholic Hospice, Inc. (CHI) has a continuing responsibility to provide excellence in patient care to our community, at the lowest possible costs; and

Whereas there exists between all categories of directors, officers and employees of CHI, a fiduciary relationship which carri es with it a strict duty of loyalty and fidelity, and

Whereas, it is the responsibility of the directors, officers, and employees of CHI, to make full disclosure of any interest on their part which might conflict with that of CHI, and

Whereas it is deemed to be timely and appropriate to adopt a policy on Conflict of Interest for the guidance of directors, officers and employees.

Directors, officers, and employees should exercise the utmost good faith in all transactions touching upon CHI and its property. They shall not use their positions or knowledge gained therefrom, directly or indirectly, so that conflict might arise betwee n CHI's interest and the individual's personal interest; and they shall not accept gifts or gratuities, excessive or unusual, directly or indi rectly, which might tend to influence judgment or actions concerning business of CHI.

All acts of directors, officers and employees shall be for the benefit of CHI in any dealings, which may affect CHI adversely.

Any contract or other transaction between CHI and one or more of its directors, officers, or employees, or between CHI and any other corporation, firm, association, or other entity in which one or more of CHI's officers, directors or employees, are directors, officers, employees or have a substantial financial interest, shall be void, unless each of the following conditions are met:

The relevant and material facts of such directors, officers or employee's interest in such contract or transaction are fully disclosed in good faith, and in advance, to the Board of Directors.

The interest the directors, officers or employees have, in the judgement of the Board of Directors, fully met the burden of proof that the contract or other transaction is fair and reasonable to CHI.

Each director, officer and employee shall be required to file a Conflict-of-Interest Statement, disclosing any interest, involvement or activity which would fall within the scope of the above policy.

A new director, officer, and employee shall file such a statement upon assumption of his/her responsibilities.

DISCLOSURE STATEMENT

I have read and am familiar with the Catholic Hospice, Inc. Resolution relating to Conflict of Interest.

☐ I have not undertaken an interest, involvement, or activity, which would contravene such Resolution.

☐ I have engaged in activities that could be classified as a Conflict of Interest. A detailed explanation is attached.

____

Signature Date

____

Type or Print Name

Privacy Release Statement

At Catholic Hospice, we are here to capture all stories. Our lives are a compilation of the unique stories made of experiences. The story of a loved one's life can be broken down into special moments we can share and remember. For this, we ask that you please take a moment to help us capture these memories. In addition, we may utilize photos to assist staff with training.

I, the undersigned, do hereby voluntarily participate and give authorization to appear in any and/all but not limited to the following:

- Photographs: Wound care, hospice setting, homelike setting, events, meetings, presentations, vendor events.
- Publications: brochures, radio, television, newspaper, or Internet (including all social media) Email Communications, and Fundraising Campaign efforts.
- Interviews with respect to the care and treatment of patients, education programs, testimonials, and any operational employee(s) and non-employee(s) activities of Catholic Hospice.

I do hereby consent to the use of the above materials in any form. I also understand that my identity may be disclosed in connection with the photographs and/or interviews.

I do hereby release Catholic Hospice, Catholic Health Services, and the Archdiocese of Miami, its agents and employees from all liability in connection with the above. I waive any right to inspect or approve the finished product, the advertising or other copy that may be used in connection with the above.
I hereby consent to the above, without expectation of remuneration to me now or in the future. This agreement shall be binding upon my heirs, personal representatives and assigns.

____
Volunteer Name/Legal Guardian
Print Name

____
Volunteer Name/Legal Guardian
Signature

____
Catholic Hospice Manager/Coordinator
Print Name

____
Catholic Hospice Manager/Coordinator
Signature

____
Date

GENERAL DESCRIPTION:

A Patient Care Volunteer's primary duty is that of a friendly visitor to both the patient and family. The volunteer provides companionship for hospice patients and short-term relief for the primary car giver.

QUALIFICATIONS:

1. Commitment to the Catholic Hospice philosophy and mission.
2. Ability to communicate effectively in English orally and in writing.
3. Willingness to travel to various locations in the Catholic Hospice service area as required.
4. Ability to interact with the public and other employees/volunteers in a positive manner and promote a cooperative working environment.
5. Ability to maintain confidentiality.
6. Commitment to one year of service.
7. Satisfactory completion of prescribed training program.

PHYSICAL REQUIREMENTS OF JOB:

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. Must be able to provide own transportation to various locations in the Catholic Hospice service area as required by duties.
2. Must be able to hear and speak for telephone/general communication.
3. Must be able to produce legible hand-written observations and comments in English on the "Volunteer Progress/Plan of Care Note".
4. Must be able to sit for extended periods of time.
5. Must be able to carry up to 25 pounds.

DUTIES:

1. Provides support services to the patient and family as requested by the Volunteer Services Coordinator. Services such as, but not limited to, reading, accompanying patient, running an errand, writing a letter, reminiscing, or playing a board game.
2. Commits to one year of service.
3. Attends the volunteer training class and any other required updates or in-services.
4. Is dependable and responsible in keeping appointments with patients and their families.
5. Documents visits and turns in "Volunteer Progress/Plan of Care Note" in a timely manner.

SUPERVISION: Volunteer Services Manager and Volunteer Coordinator

I acknowledge receipt of this job description and understand the assigned duties.

____

SIGNATURE OF VOLUNTEER DATE

PATIENT CARE VOLUNTEER TRAINING COMPETENCY

____________________________ ____________________________

Volunteer Name Manager, Volunteer Services

Date Training Completed: ____________________

Catholic Hospice competencies for new Patient Care Volunteers.

The Hospice volunteer, upon completion of volunteer training, will have:

1. Demonstrated understanding of hospice philosophy, mission, goals, and objectives.
2. Demonstrated understanding of confidentiality and signed hospice confidentiality policy.
3. Demonstrated appropriate Universal Precautions including proper hand washing and return demonstration of PPE (Personal Protection Equipment) usage; discussed Emergency Preparedness.
4. Discussed roles of members of the Interdisciplinary Team, including nurse, social worker, chaplain, and volunteer.
5. Discussed grief and bereavement issues in relations to the terminally ill patient/family and identified staff support services.
6. Discussed the importance of cultural diversity in hospice.
7. Discussed importance and utilization of hospice volunteer.
8. Reviewed volunteer documentation requirements.
9. Completed 1 hour Alzheimer training and received the Alzheimer 3-hour Self Study Program Module.
10. Fire Safety & Emergency Disaster Plan
11. Discussed Infection Control
12. Handwashing

I have received my Personal Protection Equipment (PPE) Kit.

____________________________ ________________

Volunteer Signature Date

____________________________ ________________

Volunteer Department Representative Date

CORPORATE COMPLIANCE PLAN

ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed Catholic Hospice's

Corporate Compliance Plan. I fully understand that as a staff member/volunteer/independent contractor, I have an obligation to fully adhere to its policies and principles.

I hereby acknowledge and affirm that:

1. I fully understand Catholic Hospice policy and the Compliance Plan, and I acknowledge my commitment to comply with the Catholic Hospice Compliance Plan as a staff member/volunteer/independent contractor.
2. I will report any violations of Catholic Hospice's Corporate Compliance policy by reporting concerns in one of the following ways:
    a. Call the Corporate Compliance Hotline at 1800-785-1436
    b. Report to a supervisor (or)
    c. Report to the Compliance Officer

____

Date

____

Signature

____

Printed Name of Care and Service Provider

____

Witness Signature

____

Printed Name of Witness

Initial: May 1990

Rev: August 2010

Current: October 27, 2011

SEXUAL ABUSE

Any person who knowingly and willfully fails to report a case of known or suspected abuse, neglect, or exploitation, or who knowingly and willfully prevents another person from doing so, commits a misdemeanor of the second degree.

A person who knowingly and willfully makes public or discloses any confidential information contained in the central abuse hotline, or in other computer systems, or in the records of any case of abuse, neglect, or exploitation of a vulnerable adult or child, commits a misdemeanor of the second degree.

A person who knowingly and willfully makes a false report of abuse, neglect, or exploitation of a vulnerable adult or child, or a person, who advises another to make a false report, commits a felony of the third degree.

Initial: October 2002

Current: November 2008

Acknowledgement and Understanding of Sexual Abuse Policy

I understand that it is my responsibility to abide by all rules contained in the policy. I also understand how to report incidents of sexual abuse as set forth in the abuse policy, including retaliating against any employee/volunteer exercising his or her rights under the policy.

Employee/Volunteer Print Name	Employee/Volunteer's Signature
______________________________	______________________________

Date: ______________________________

CHILD ABUSE

Investigation and Follow-up:

The Organization will take all allegations of child abuse seriously and will promptly and thoroughly investigate whether child abuse has taken place. The Organization may use an outside third party (such as a private investigative agency) to investigate. The Organization will cooperate fully with any investigation conducted by law enforcement or other regulatory agencies. It is the Organization's objective to conduct a fair and impartial investigation. The Organization provides notice that they have the option of placing the accused on a leave of absence or on a reassignment to non-patient contact pending investigation.

Acknowledgement and Understanding of Child Abuse Policy

I acknowledge that I have received and read the child abuse policy and/or have had it explained to me. I understand that the organization will not tolerate any employee, volunteer, board member or third party who commits child abuse. Disciplinary actions will be taken against those who are found to have committed child abuse.

I understand that it is my responsibility to abide by all rules contained in the policy. I also understand how to report incidents of child abuse as set forth in the abuse policy, including retaliating against any employee/volunteer exercising his or her rights under the policy.

Employee/Volunteer Print Name	Employee/Volunteer's Signature
____________________	____________________

Date: ____________________

ALZHEIMER 1 HOUR TRAINING COMPLETED

Received the Alzheimer 3-hour Self Study Program and Tests

Print Name: ______________________________ Date: __________________

Signature: ______________________________

Manager Name: __________________________ Date: ____________________

Manager Signature: ______________________

POST TEST QUESTIONS FOR VOLUNTEER TRAINING CLASS

1. When you have a concern or problem about a patient you should call the Patient Care Manager and then call the Volunteer Service Manager.
2. Only a medical doctor can refer a patient to Catholic Hospice.
3. Volunteers are an important part of the interdisciplinary team and as such must document their visits to our patients in a timely manner, usually once a week.
4. Once a patient signs on to Catholic Hospice care, they are always on Catholic Hospice.
5. One of the most important precautions you can take to prevent the spreading of diseases is to wash your hands.
6. The chaplain and the social workers are the only members of the team who should discuss spiritual and religious matters with the family and/or patient.
7. If possible, funeral arrangements are made when the Admissions nurse interviews the family while putting the patient on our program and these arrangements can be found in their Catholic Hospice folder in the home.
8. Only patient care volunteers are expected to update their personnel files annually with their current driver's license and other pertinent data.
9. Palliative care means that the patient is never given chemotherapy, radiation, or IV's.
10. Bereavement counseling begins with anticipatory grief visits to the family while the patients are alive.
11. See the answer sheet for this question.
12. See the answer sheet for this question.

TEST FOR VOLUNTEER TRAINING CLASS

NAME OF VOLUNTEER ____________________ DATE ________________

As the questions is read to you, please circle T= true or F= false

1. T F
2. T F
3. T F
4. T F
5. T F
6. T F
7. T F
8. T F
9. T F
10. T F
11. The interdisciplinary team consist of:
    1. ____________________________
    2. ____________________________
    3. ____________________________
    4. ____________________________
12. Having completed this training, do you think you will be comfortable volunteering to visit patients?

    YES NO, I prefer to volunteer in the North or South office.

If yes, what three qualities do you believe you have to offer Catholic hospice?

1. ____
2. ____
3. ____