Marion Senior Services
MEALS • TRANSIT • IN-HOME SUPPORT

FOR OFFICE USE ONLY

BCGD: Level 1 [ ] Level 2 [ ]
MC OK [ ], FDLE OK [ ]
NSOPW [ ]

VOLUNTEER APPLICATION

Please complete **all** information and **print** legibly

NAME: _____

EMAIL ADDRESS: _____

ADDRESS: _____

CITY: _____STATE: _____ ZIP CODE: _____

CONTACT NUMBER: (H)_____(C)_____

BEST TIME TO CONTACT YOU: [ ] before _____am/pm [ ] after _____am/pm

DATE OF BIRTH (MONTH/DAY/YEAR): _____GENDER (MALE/FEMALE): _____

DRIVER'S LICENSE NO: _____ STATE ISSUED: _____

DRIVER'S LICENSE EXPIRATION DATE: ____/_____/_____ CAR INSURANCE: YES/NO

SOCIAL SECURITY NO: _____-_____-_____ RASMUSSEN STUDENT: [ ] Yes [ ] No

HAVE YOU PREVIOUSLY VOLUNTEERED, YES/NO? IF SO, WHERE?

_____

TRANSPORTATION: Do you have a reliable vehicle? [ ] Yes [ ] No

Please check your primary area of volunteer interested:

❑ Friendly Visitor (see below)	❑ Telephone Reassurance (see below)
❑ Meals on Wheels	❑ Commodity Food Program
❑ Office Assistant	❑ Guest Services
❑ Fundraising	❑ Event Assistant
❑ Christmas Angel Tree Project	❑ Pet Pantry Aide
❑ Random Acts of Kindness	❑ Community Events
❑ Other:	

Highlighted items not taking applications at this time.

OTHER AREA(S) OF INTEREST? _____

AVAILABLE START DATE: _____ ❑ SEASONAL? ❑ YEAR-ROUND?

revised 06/2023 GT

EDUCATION: _____

HOBBIES AND INTERESTS: _____

ARE YOU CURRENTLY EMPLOYED? [ ] YES [ ] NO EMPLOYER: _____

HOW DID YOU HEAR ABOUT MARION SENIOR SERVICES?

❑ Word of Mouth/Friend	❑ Newsletter
❑ Email	❑ Walk - In
❑ Social Media	❑ Speaking Engagement
❑ Fundraising Event	❑ MSS Client

EMERGENCY CONTACT INFORMATON

In case of emergency, you have permission to notify the following:

NAME_____

CONTACT NUMBER: _____

RELATIONSHIP: _____

PLEASE LIST 2 REFERENCES:

NAME: _____ PHONE: _____

EMAIL: _____

RELATIONSHIP: _____

NAME: _____ PHONE: _____

EMAIL: _____

RELATIONSHIP: _____

CONSENT FOR BACKGROUND CHECK FORM

I, _____(please print),
Pursuant to the Federal Fair Credit Reporting Act, grant permission to Marion Senior Services, Inc. and its agents and representatives, the irrevocable and unrestricted right to conduct background screening in accordance with DOEA (Department of Elder Affairs) Guidelines. I understand that the scope of this background may include but is not limited to:

- Verification of Social Security Number
- Current and Previous Residences
- Employment history, Education, References
- Criminal history Records
- Birth Records
- Workers' Compensation claim records
- Motor Vehicle Reports and any other public records

I hereby release Marion Senior Services, Inc. and its legal representatives for all claims and liability relating to said background check.

Name(s) (Maiden): _____

Signature: _____Date: _____

CONFIDENTIALITY STATEMENT

I shall respect the privacy concerns of the people we serve, and I shall hold in confidence all information obtained in the course of volunteer service, whether that information is obtained through written records or personal interaction. Therefore, I will not disclose an individual's confidences to anyone except:

1. As mandated by law.
2. To prevent a clear and immediate danger to a person or persons.
3. Where I am compelled to do so by a court or pursuant to the rules of the court.

I shall store or dispose of professional records in ways that maintain confidentiality.
I shall possess a professional attitude which upholds confidentiality toward the people we serve, colleagues, applicants and any sensitive situations arising within Marion Senior Services.
I, upon my termination, shall maintain client and co-worker confidentiality and I shall hold confidential any information about sensitive situations within this agency.
I understand that violation of this confidentiality statement may be grounds for immediate dismissal.

HIPAA TRAINING and ACKNOWLEDGMENT FORM

Marion Senior Services, Inc. (MSS)

Uses and Disclosures of Protected Health Information Policy

PURPOSE: This policy explains the process for using or disclosing Protected Health Information

POLICY:

1. All MSS staff will receive training regarding HIPAA compliance and MSS policies and procedures for the use and disclosure of Protected Health Information.
2. All staff will recognize that PHI cannot be used or disclosed except as described in MSS policies and procedures.
3. The HIPAA Safety and Compliance Officer is the Human Resources Director.
4. MSS will recognize that uses and disclosures can be made to carry out treatment, payment, or healthcare operations (TPO).
5. MSS will recognize that certain uses and disclosures require written authorization for the release of confidential information.
6. MSS will recognize that certain uses and disclosures require an opportunity for the participant to agree or to object.
7. MSS will recognize that certain uses and disclosures do not require participant authorization or an opportunity for the participant to agree or to object. These disclosures include:
   - Disclosure made to another "covered entity" for the treatment, payment, and operations.
   - Disclosure to Payers (i.e. Florida Network, DCF, SAMH, PFSF, LSF Health Systems)
   - Disclosures made to the Public Health Authority to assist in preventing or controlling disease, injury, or disability.
   - Disclosures for the purpose of research (upon approval from the Institutional Review Board).
   - Disclosures for products regulated by the FDA.
   - Disclosures necessary for disaster relief agencies.
   - Disclosures made for the purpose of reporting Abuse, Neglect, and Domestic Violence.
   - Disclosures made to law enforcement in order to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
   - Disclosures related to violent criminals.
   - Disclosures made pursuant to legal orders.
   - Disclosures of crimes occurring on the premises of MSS programs.

- Disclosures made to the Department of Health and Human Services for regulatory oversight.
- Disclosures that have an impact on issues of National Safety, Intelligence, or Counterintelligence.

8. All staff members, as required by statute, are responsible for reporting suspected child or elder abuse in accordance with MSS policies and procedures. All staff are required to make "duty to warn" reports to the appropriate authorities. The Privacy Officer (Human Resources Director) will be consulted regarding all other non-routine disclosures. All non-routine disclosures require that only the minimum PHI that is necessary be disclosed.
9. The Privacy Officer will be consulted regarding all non-routine requests for PHI.
10. Cases of suspected child or elder abuse will be reported as required by Florida Statute (cases will be staffed on an individual basis with the Privacy Officer and/or designee to determine whether it is in the best interest of the participant to provide notice of the disclosure. The notice of disclosure form will be completed as appropriate).

11. All staff shall make every effort to keep client PHI confidential, by several methods such as:
    a. Securing documents with client names
    b. Never leave your emails and/or computer screens open when not using
    c. Never discuss or share client's health issues or concerns in a public place or with persons without the need to know.
    d. Do not print documents with PHI unless you are going to be at the printer to retrieve the document immediately.

PHOTO/VIDEO RELEASE FORM

I, _____(please print), grant permission to Marion Senior Services, Inc. and its agents and employees the irrevocable and unrestricted right to reproduce the photographs and/or video images taken of me, or members of my family, for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium.

I hereby release Marion Senior Services, Inc. and its legal representatives for all claims and liability relating to said images or video. Furthermore, I grant permission to use my statements that were given during an interview or guest lecture, with or without my name, for the purpose of advertising and publicity without restriction. I waive my right to any compensation.

As a courtesy to Marion Senior Services, the volunteer may not use any likeness of Marion Senior Service in any social media or promotion of their own business or for compensation. Permission must be granted from the agency for any use of its image.

I acknowledge that I am (check one):

[ ] over the age of 18

[ ] the legal guardian of the following If legal guardian of model(s), please list name(s) here:

Name(s): _____

Legal Guardian Signature: _____

Applicant Signature:

By signing this application, I agree to abide by all policies and procedures of Marion Senior Services, including confidentiality requirements. I also understand that a background screen will be performed and failure to pass will result in not joining the agency as a volunteer.

Signature: _____

Date: _____

PLEASE SUBMIT COMPLETED APPLICATION TO: reception@marionseniorservices.org

For questions or more information, please contact:
352-620-3501
Office Location: 1101 SW 20th Court, Ocala, FL 34471

********** THIS AREA FOR OFFICE USE ONLY**********

Signature of Nutrition &Outreach Director:	Date: