Home Delivered Meals (HDM) Volunteer Application

OFFICE USE ONLY!
____/____/20____
Today's Date

Last 4 of Social Security
- ## - __ __ __ __

Volunteer Information

____ ______/______/______
Last Name *First Name* *Middle Initial* *Suffix (Dr., Jr., Sr.)* *Date of Birth*

____
Preferred First Name / Nick Name

Residential/Mailing Address

Is your postal/mailing address exactly the same as the residential address? ❑ No ❑ Yes

________________________ ________________ **PA** ________________
Street Address *City* *State* *Zip*

________________________ ________________________
PO Box If Applicable *Municipality/Borough/Township*

(_____) ______-________ ❑ Home ❑ Cell (_____) ______-________ ❑ Home ❑ Cell
Primary Phone # *Secondary Phone #*

____
Email Address

Emergency Contact Information

________________________ (_____) _____ - ________ ________________________
Physician's Name / Practice *Phone* *Street Address*

________________________ (_____) _____ - ________ ________________________
#1 Emergency Contact Name *Phone* *Relationship*

________________________ (_____) _____ - ________ ________________________
#2 Emergency Contact Name *Phone* *Relationship*

Application Questionnaire

1) **What is your gender?** *Please Select ONLY ONE!* ❑ Female ❑ Male
2) **Marital Status:** *Please Select ONLY ONE!* ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
3) **What is Your Ethnicity?** *Please Select ONLY ONE!*

❑Hispanic or Latino	❑Not Hispanic or Latino	❑Unknown

4) **What Is Your Race?** *Please Select ONLY ONE!*

❑American Indian/Native Alaskan	❑Native Hawaiian/Other Pacific Islander	❑Unknown/Unavailable
❑Asian	❑Non-Minority (White, non-Hispanic)	❑Other ________________
❑Black/African American	❑White-Hispanic	

5) **Are you Employed?** ❑ Full-Time ❑ Part-Time ❑ NOT Employed

If Employed: Place of Employment: ________________________ Co. Phone

APPLICATION QUESTIONNAIRE CONTINUED

6) Do you have a valid driver's license? ❑ YES ❑ NO

7) Is your vehicle available for your own transportation? ❑ YES ❑ NO

8) Do you have auto insurance that covers passengers riding in your car? ❑ YES ❑ NO

9) Do you have physical limitations? ❑ YES ❑ NO

If YES, Please List:____

____

REFERENCES

(Please list two (2) personal references who have known you for at lease one (1) year)

____

#1 Reference Name

____

How do you know this person? (Co-Worker, Friend, etc.)

(_____) _____ - ________

Phone

____

#1 Reference Address

____

#2 Reference Name

____

How do you know this person? (Co-Worker, Friend, etc.)

(_____) _____ - ________

Phone

____

#2 Reference Address

SKILLS

Please list any special or unique talents, and/or specific skills you are willing to share with us.

____

____

____

____

ATTACH A COPY OF DRIVER'S LICENSE / STUDENT ID / VEHICLE REGISTRATION & INSURANCE

❑ **By checking this box:**

I understand that, as a volunteer, I will help the agency to the best of my ability and will maintain complete confidentiality concerning all information on clients and/or agency.

X ____ ______________

Volunteer Signature *Date*

HIPPA LAW UPDATES

The York County Area Agency on Aging notified Senior Community Centers of HIPPA law(s) that affects the confidentiality of our members and home-delivered meals consumers. The law is explained below and we are asking for your signature after you have read, understood and will abide by the confidentiality issue.

Confidentiality Issues

Health Insurance Portability and Accountability Act of 1996 (HIPPA)
Public Law 104-191-signed on August 21, 1996 – based on the Kennedy-Kassebaum bill.

Primary Goal:
Make it easier for people to keep health insurance and help the industry control administrative costs.

Components

Title I Health Insurance Portability

Title II is designed to Reduce Health care fraud and abuse

Guarantee security and "privacy" of health information

Enforce standards for health information and transactions

Title III Tax Related Provisions

Title IV Application and Enforcement of Group Health Plan Requirements

Title V Revenue Offsets

Effective Date

October 16, 2002 for Electronic Data Transfer and April 14, 2003 for Privacy.

Privacy Rule

Gives people more control over their health information

*Sets boundaries on the use and health care providers and others must achieve to "protect privacy" of health information. Holds violators accountable with civil and criminal penalties that can be imposed if person's rights are violated. It strikes a balance when public responsibility requires disclosure of some forms of data- for example to protect the public health.

Protected health information

Includes individually identifiable health information that is transmitted electronic media, maintained in any electronic media, transmitted or maintained in any other form (including oral or written).

Two concepts:

Consent – A person's written consent before using or disclosing their personal health information to carry out treatment, payment or health care operations.

Authorization – More customized document that gives the provider permission to use the information for other specific purposes, for example for a research project.

Penalties

Civil - $100 per violation up to $25,000 per year for multiple violations

Criminal - $50,000 fine, one year in prison or both. If under False pretenses $100,000 fine, five years in prison or both. If under Criminal Intent to sell, transfer $250,000 fine, ten years in prison or both.

How are you affected?

Responsibilities to maintain privacy as Business Associates of YCAAA.

I have read the above HIPPA law and understand that as a volunteer I will be expected to maintain consumer'' confidentiality.

____
PRINT Name

*X*____ ______________
Signature *Date*

Revised 9/10