

Certified Volunteer Long Term Care Ombudsman (VOP) Application

Name: _____

Address: _____

City, Zip Code: _____

Preferred phone number: _____ Home Work Cell

Secondary phone number: _____ Home Work Cell

Are you at least 18 years of age? Yes No

E-mail: _____

Employment Status: Full-Time Part-Time Retired Student Other

Occupation/Former Occupation:

How did you learn about the Volunteer Ombudsman opportunity?

Why do you want to be a Volunteer Ombudsman?

Describe your past and present volunteer experiences.

Describe any skills or strengths you have that would be valuable to the VOP.

Do you speak any languages other than English? Yes No If yes, what is your level of fluency?

Will you be able to spend up to a minimum of three hours every month visiting an assigned facility?
 Yes No

Will you be able to attend a mandatory eight hour training session? Yes No

Will you be able to commit to one year of volunteer service? Yes No

If no, are you a college student or seasonal traveler who spends several months in another state during the year? Yes No

Would you be able to commit to at least nine months of volunteer service to the Volunteer Ombudsman Program? Yes No

Will you commit to attending periodic in-service and continuing education sessions provided by the Office of the State Long Term Care Ombudsman? (Not to exceed 10 hours in the first year and 6 hours each year thereafter) Yes No

Will you be able to provide your own transportation? Yes No

Name and town of the facility where you would like to serve as a Certified Volunteer Long-Term Care Ombudsman (if known)?

All Volunteer Ombudsmen will need to pass a comprehensive criminal background check before their service begins. Are you willing to consent to a criminal history records check? Yes No

Conflict of Interest

Please note when answering the questions below:

Immediate family includes father, mother, son, daughter, brother, sister, aunt, uncle, first cousin, nephew, niece, wife, husband, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepparent, stepbrother, stepsister, stepchild, half-sister, half-brother, grandparent, or grandchild.

Long-term care facility includes nursing facility, residential care facility, elder group home and assisted living.

Do **you** or any of **your immediate family members** currently work, or have previously worked, for a long term care facility or participated in the management, ownership, or operation of a long-term care facility within the previous year?

Yes No

If yes, please provide the name of the facility, the position held, and the duties associated with this role.

Have **you** or any of **your immediate family members** owned or had a financial interest in any existing or proposed long term care facility or service in the past two years? Yes No

If yes, please explain:

Have **you** or any of **your immediate family members** been involved in the licensing or certification of a long term care facility or the provision of a long-term care service in the past two years?

Yes No

If yes, please explain.

Have **you** or any of **your immediate family members** received any form of payment, gifts, or gratuity from a long-term care facility, owner, operator, resident, or resident representative in the past two years? Yes No

If yes, please explain.

In the past two years, have **you** or any of **your immediate family members** provided services such as (including but not limited to financial, insurance, legal, business, ministry, etc.) to residents of a long-term care facility in which a member of your immediate family resides? Yes No

If yes, please explain.

In the past two years, have **you** or any of **your immediate family members** participated in activities which negatively affect the ability to serve residents or which are likely to create a perception that the primary interest is other than as an advocate of the resident? Yes No

If yes, please explain.

In the past two years, have **you** or any of **your immediate family members** resided in a long-term care facility? Yes No

If yes, please provide the name and location of the facility.

Please note: If you have marked yes to any of the above questions, you may be asked to complete more documentation.

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

Name	Relationship
Phone	Email address (if available)

IMPORTANT—PLEASE READ

If I am accepted as a Certified Volunteer Long Term Care Ombudsman, I agree to read the volunteer training manual and participate in orientation prior to beginning my volunteer duties.

I agree to spend a minimum of three hours each month in the assigned facility visiting residents, keep a journal of resident visits, and report identified concerns and resolutions for resident problems to the VOP Coordinator.

I agree to complete an additional ten hours of training in the first year of assignment and six hours of training each year thereafter.

I understand that failure to fulfill these responsibilities may result in termination of volunteer duties.

VOLUNTEER PROGRAM

I understand that I am applying to be a Certified Volunteer Long Term Care Ombudsman for the Iowa Department on Aging, Office of the State Long Term Care Ombudsman.

My volunteer work will be conducted in a long term care facility, but I understand that I am NOT a volunteer for the facility.

I understand that I can contact the VOP Coordinator at any time for information or assistance and that contacts and referral procedures will be spelled out in my training.

By signing this application, I verify that all information is true and correct; I understand the responsibilities associated with this volunteer position and agree to abide by these terms.

Signature _____ Date _____

Mail completed application to:
Volunteer Ombudsman Program Coordinator
Iowa Dept. on Aging, Jessie M Parker Bldg., 510 E 12TH St, Rm 2, Des Moines, IA 50319