Volunteer Service Application

Hillcrest Health Services 1820 Hillcrest Drive, Suite B Bellevue, NE 68005
hillcrestvolunteers.com 402.934.2376

Name: _____

Group/Organization: _____ Date of Birth: _____

Address: _____City: _____State: _____ Zip: _____

Email: _____ Telephone: _____ Home/Work/Cell

Emergency Contact Name: _____ Phone Number: _____

Preferred method of communication: ___ email ___ phone

How did you hear about this volunteer opportunity? _____
Has a civil or criminal complaint ever been filed against you that alleged sexual misconduct or abuse? **Yes No**
Have you ever been convicted of a crime (misdemeanor or felony) or minor traffic violations? **Yes No**
Have you ever been terminated from a volunteer service or employment due to misconduct toward a patient/client/customer/participant? **Yes No**
If **Yes** on any of the above, please explain: _____
Are you 18 years of age or older (under 18 need to have consent) **Yes No**
Have you ever volunteered for Hillcrest Health Services? **Yes No**
If yes, give details: _____
Have you received a COVID-19 vaccine? **Yes No**
If yes, please email a copy of your vaccination card with this application.

Time preference: __ Morning __ Afternoon __ Evening

Day(s) of week preferred: _____

Length of time you wish to serve in one session: __ 1 Hour __ 2 Hours __ 3 Hours __ Longer Periods

Location: __ Hillcrest Country Estates Cottages (Papillion) __ Hillcrest Country Estates Grand Lodge (Papillion)
__ Hillcrest Shadow Lake (Papillion) __ Hillcrest Home & Community Services (Bellevue) __ Hillcrest Mable Rose (Bellevue)
__ Hillcrest Health & Rehab (Bellevue) __ Hillcrest Hospice (Nebraska) __ Hillcrest Hospice (Iowa)
__ Hillcrest Millard (Omaha) __ Hillcrest Silver Ridge (Gretna) __ Hillcrest Firethorn (Lincoln)

Are there any skills drawn from previous experiences you would care to use in volunteer work (hobbies, talents, work or volunteer experiences)? _____
_____

Confidentiality Agreement

Volunteers have access to confidential information. It is the volunteer's moral, professional and legal obligation to keep all information regarding customers, the organization and team members confidential. All people have certain information that they would not wish to be shared with others. It is important for the dignity of those we care for, and work with, to respect the right of confidentiality. It is the responsibility of all volunteers to safeguard all confidential information.

As long as I am a volunteer with Hillcrest Health Services I agree to follow company, state and federal confidentiality laws and regulations as well as all Hillcrest Health Services policies and procedures.

_____
Signature Date

What volunteer opportunities are you interested in?
Community Volunteer Programming

__ Group that is already formed
__ Happy hours
__ Leading/assisting with crafts
__ One-on-one visits
__ Other: _____
__ Bingo
__ Assist with holiday parties
__ Outings
__ Office support/clerical
__ Polish nails
__Bible study
__Musical talents
__Pet visitation*

*Pet visitation volunteers must submit the pet's current vaccination records as well as a therapy animal certification and/or recommendation letter of good behavior from a veterinarian.

Hospice Volunteer Programming

__ One-on-one visits with Hillcrest Hospice patients
__ Veteran-to-veteran care
__ No One Dies Alone Program
__ Administrative support

Questions for Hospice Volunteers Only

Have you had a family member or friend use hospice services? If so, who and how long has it been since they were a hospice patient? _____

Have you lost a loved one in the last year? If so, do you believe this will have a positive or negative impact on your volunteer service? _____

_____

Level IV: Internship/Practicum

School/College/University: _____

Student requirements for internship/practicum: _____

_____

In signing your name below, you are indicating that all of the information you provided is true, correct and complete.

_____

Print Name Signature Date

Parental/Guardian Consent for Minor

Your son/daughter has expressed an interest in participating in Hillcrest Health Services' Volunteer Program, and they are under 18 years of age. Since volunteering requires a commitment of time, training and transportation, we are requesting your written permission for your son/daughter to participate. Please sign and date this consent form acknowledging that your son/daughter will participate in volunteer opportunities and that you accept responsibility for their transportation.

I give permission for my son/daughter to perform volunteer service within Hillcrest Health Services. I have discussed this commitment with them and support their efforts.

Son/Daughter's Name (please print): _____

Son/Daughter's Date of Birth: _____

Name of Parent/Guardian (please print): _____

Signature of Parent/Guardian: _____

Date: _____

Infectious Disease Volunteer Information: COVID-19

1. Volunteer agrees to wear appropriate PPE, which will be provided by Volunteer Services or the Hillcrest community. This includes a surgical mask for every visit. Volunteers may also be asked to wear a face shield, N-95 mask, gown and gloves.
2. Volunteer will be screened upon entering our communities, including temperature check and answering COVID-19 symptom and exposure questions.
3. Volunteer will follow guidelines for hand cleanliness, including using hand sanitizer frequently and washing hands with warm soap and water.
4. Volunteer will follow the community's guidelines on social distancing and refer to the recreation director for further guidance.
5. Communities may cancel visits from volunteers during an ongoing health risk.
6. Volunteers must be fully vaccinated and provide a copy of their vaccination card to volunteer in person. Please return this application with a copy of your vaccination card.

I agree to abide by the policies set by Hillcrest Health Services regarding COVID-19

Volunteer Signature_____

Volunteer Services Signature_____