# SP-20-0005

# Attachment 6: Volunteer Documents

## Volunteer Self-Assessment

Tell us something about you:

Likes and Dislikes:

Favorite Food, candy, television show, restaurant:

Hobbies:

# ARKANSAS SHIIP VOLUNTEER APPLICATION

Date: _____

Applicant Name: _____

Date of Birth: _____

Address:
Street: _____
City:_____ State: _____
Zip:_____County: _____

Home Phone: (  ) _____
E-Mail Address: _____

Emergency Contact Information:

Name: _____

Relationship:_____Home Phone: (__)_____

**SHIIP Volunteer Descriptions**

Which of the following volunteer positions interest you?

- ☐ Medicare Beneficiary Advisor-Provide unbiased Medicare health insurance information, counseling and assistance to Medicare beneficiaries and their representatives. Training provided.
- ☐ Administrative Support Specialist-Provide administrative support including data entry, answering phone, scheduling appointments and other clerical duties.
- ☐ Public Information Representative-Promote community awareness of the SHIIP program and its services by giving presentations to Medicare beneficiaries, caregivers and providers on selected topics; attending community events such as health fairs, and Senior Expos.
- ☐ Multimedia Specialist-Provide photography services for health fairs, presentations, trainings, create graphic designs for websites, use digital cameras, and use creative ideas for newsletter.
- ☐ SHIIP Medicare Minute Volunteer-Educate the community about SHIIP and Medicare by making short presentations called "Medicare Minutes" to groups of Medicare beneficiaries and their caregivers.

Why are you interested in volunteering for AR SHIIP? _____

_____

Are you fluent in any language other than English (including sign language)?

☐ Yes (Please list which language): _____
☐ No

**Skills and Interest (Please check all that apply)**

| | |
|---|---|
| | Computer/Internet |
| | Data Entry |
| | Teaching/Training |
| | Graphic Design |
| | General Clerical |
| | Medicare Minutes |
| | One-on-one Client Service |
| | Attending Events /Health Fairs |

**Availability**
Hours per month: □4 or less □ 5 to 10 □ More than 10

Preferred Days: ____ Mo ____ Tu ___We ___Th ___Fr ___Sa (Health fairs)

Preferred Times: ____Mo ____Tu ____We ____ Th ___Fr ___Sa (Health fairs)

Volunteer Commitment: __3-6 months __ 6-9 months __ 9-12 months __ 1-2 years

Do you have a current driver's license and reliable transportation?
☐ Yes
☐ No

Do you have current Liability Auto Insurance?
☐ Yes
☐ No

Driver License Number and State:_____

**Employer Information**

Company/Organization:_____

Dates of Service From: _____To_____

Contact Person: _____ Phone: ( )_____□ Employee □Volunteer

Please list three references whom you are not related to and not current employees or volunteers of SHIIP.

1. Name: _____
   Relationship: _____
   Phone number: _____
   Years Known: _____

2. Name: _____
   Relationship: _____
   Phone number: _____
   Years Known: _____

3. Name: _____
   Relationship: _____
   Phone number: _____
   Years Known: _____

I declare that the information provided and statements made in this application are true and complete to the best of my knowledge and belief. I also declare that I understand that the purpose of the training I receive as a volunteer is to provide services free of charge to Medicare beneficiaries and is not to be used for my personal monetary gain.

Signature: _____ Date: _____

ship state health insurance assistance programs
NATIONAL NETWORK

LOCAL HELP FOR PEOPLE WITH MEDICARE

STATE INSURANCE DEPARTMENT
STATE OF ARKANSAS

# Arkansas SHIIP Assurance Agreement

As a volunteer for SHIIP, I agree to act within the scope of my responsibilities and abide by all program policies and procedures as specified in, but not limited to, the following:

I will adhere to volunteer job descriptions, handbooks, manuals, and other guidance. SHIIP is not responsible for any activity that I engage in or any responsibility that I assume other than those specified in the above mentioned program policies and procedure. Any actions that I take outside the scope of responsibility for my volunteer position will be taken at my own personal risk.

**Nature of Volunteer Service**:

- I understand that as a volunteer, I will be relied upon to serve Medicare beneficiaries and their community. The scope of responsibilities varies for each volunteer.
- I understand that my responsibilities may also include the use of internet-based programs to help clients compare health and prescription drug plan options.
- I understand that my responsibilities may also include educating the public on Medicare, Medicaid, and health insurance issues that affect older Americans and people with disabilities.
- I understand that my volunteer activities may need to take place at specific counseling sites, and also by telephone.
- I understand that I must submit monthly documentation of my activities to my volunteer coordinator.
- I understand that volunteers provide services free of charge to any Medicare beneficiary who seeks assistance from the program.

**Confidentiality**:

- I understand that I will have access to sensitive information about my clients, including medical, insurance, financial, and other confidential personal data.
- I agree to keep such information confidential and to use it only to perform my duties as a SHIP/SMP volunteer, to the extent that a client explicitly authorizes.

**Non-Conflict of Interest**:

MAP volunteers cannot promote private or personal interests as they go about performing the duties described in the volunteer program policies and guidelines. To comply with this requirement, I agree to the following.

- I will in no way attempt to conduct market research, or solicit or persuade clients to purchase or enroll in a specific type of health insurance coverage, to switch from one carrier to another to replace existing insurance coverage, to go to a specific provider of service for treatment, or to direct a client to a specific agent/broker, or to any profit-based billing service.
- I will not disclose or use confidential or other personal information obtained from a client through my association with MAP for personal gain or the gain of my employer or any other party.

**Agreement**:

- I understand that as a volunteer, I am committing to hours each month.
- I agree to attend initial and update training program as required.
- I agree to respect the confidentiality of my clients and to exercise good faith and integrity in performing my duties as a MAP volunteer.
- I agree to complete a background check.
- I understand that a breach of this agreement will result in termination of my volunteer service and may subject me to liability for harm that I cause to a client through a breach of confidentiality or acting outside the scope of my responsibilities.

Volunteer Signature: _____

Date: _____