



VOLUNTEER PACKET

Thank you for your interest in becoming a volunteer for Sheltering Arms Senior Services.

The following items are included in this packet:

1. **Volunteer Application:** This form requests basic information, references, and volunteer interests and availability.
2. **HIPAA Privacy In-Service Post Test:** This is a basic test of HIPPA knowledge. Please take this test after studying the brief HIPPA training manual "[The HIPPA Privacy Rule and Our Privacy Practices.](#)" ,<link to pdf of training>
3. **HIPPA Privacy Training Volunteer Certification Statement:** This form will be reviewed by the Sheltering Arms Senior Services privacy official.
4. **Acknowledgement of Receipt of Notice of Privacy Practices:** This form indicates that you have received a copy of our Privacy Practices, [available online.](#) <link to Notice of Privacy Practices>
5. **Volunteer Confidentiality Agreement:** This form includes directions on maintaining the confidentiality of our clients.
6. **Volunteer Background Screening Form:** This form gives us permission to conduct a background check.

To apply to become a Sheltering Arms Senior Services volunteer, these items will need to be completed and submitted online or mailed to:

Sheltering Arms Senior Services
3838 Aberdeen Way
Houston, TX 77025-2416
Attn: Volunteer Services



VOLUNTEER APPLICATION

Complete and mail to Sheltering Arms Senior Services, 3838 Aberdeen Way, Houston, TX 77025.

Applicant: _____		Home Phone: _____	
Work Phone: _____		E-mail Address: _____	
Address: _____		City: _____	Zip: _____
Date of Birth: _____		Sex: _____	Race: _____
Company/School: _____		Occupation: _____	
Education (please indicate highest grade completed):			
<input type="checkbox"/> Elementary School <input type="checkbox"/> High School <input type="checkbox"/> Vocational or Technical Training <input type="checkbox"/> College <input type="checkbox"/> Graduate School			
Name of School: _____			
Please list any languages you speak fluently other than English: _____			
Please list your skills, hobbies or special interests: _____			
How did you learn about our volunteer programs? _____			
Please describe any previous volunteer and/or work-related experiences with older adults: _____			

In case of emergency please notify:			
Name: _____	Phone: _____	Relationship: _____	

REFERENCES

Due to the nature of the agency's opportunities, all applicants must provide references. References will be contacted before an applicant is considered for volunteer service. In addition, any criminal convictions received within the last 10 years will be reviewed by the staff on a case by case basis before an applicant is approved for volunteer service.

Please list two references (not relatives):

Name	Address/City/State/Zip	Home Phone and Work Phone

Have you been convicted of a misdemeanor (excluding traffic violations), felony or violated the Texas Controlled Substance Act within the last 10 years? Yes No

If yes, please explain: _____

Please check the areas for which you wish to volunteer:

- Telephone Reassurance Adult Day Center (Central) Gift Baskets
 Home Repair Birthday Club
 Special Events Office Volunteer

Please indicate day(s) and time(s) you would like to serve:

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM

Please indicate your preference for the type of older adult with whom you wish to be matched (please number your preferences):

- ___ Male ___ Black ___ Lives Alone
 ___ Female ___ Anglo ___ Lives With Family/Caregiver
 ___ No Preference ___ Hispanic ___ No Preference
 ___ Other
 ___ No Preference

Please indicate area of town preferred (if applicable):

- NE NW SE SW Central (Inside the Loop) No Preference

VOLUNTEER WAIVER AND AGREEMENT

Waiver

Waiver must be signed by volunteer or parent/guardian if volunteer is less than 18 years of age.

In consideration for serving as a volunteer for Sheltering Arms Senior Services, I hereby release Sheltering Arms Senior Services from any and all claims for personal injury or property damage which claims arise directly or indirectly from my participation in a volunteer capacity. I understand and agree that my service at Sheltering Arms Senior Services is voluntary. Further, I expressly represent that I am not suffering from any disease or physical condition which could result in my death or injury as a result of my volunteer service for Sheltering Arms Senior Services.

I have read this release of liability statement and understand its meaning. By signing on behalf of a volunteer less than 18 years of age, the parent/guardian also expressly agrees to all the above.

Signature

Date

Agreement

I affirm that the information that I have provided on this application is true and correct to the best of my knowledge.

I understand that I will not receive any remuneration for my service.

I understand that information I receive about a client is confidential and I agree not to disclose this information to anyone other than Sheltering Arms staff.

Volunteer Signature

Date

To be completed by office staff

Date application received: _____ Date trained: _____ Trainer: _____ Program Code: _____



HIPAA Privacy In-Service Post-Test

Name:

Date:

Please circle the correct answer:

1. The Transactions Rule, Security Rule and Privacy Rule are:
 - a. new components of the Medicare Conditions of Participation.
 - b. part of the Administrative Simplification provisions of the HIPAA legislation.
 - c. intended to ensure quality health care is provided to all patients.
 - d. concerned with reducing the health care benefits provided to patients.

 2. The HIPAA Privacy Rule:
 - a. provides patients with more control over how their health information is used and disclosed.
 - b. provides a minimum level of privacy protection for all health care consumers.
 - c. requires that health care agencies develop systems and processes to ensure that patient's health information is safeguarded from wrongful use or disclosure.
 - d. all of the above.

 3. Protected health information is:
 - a. any information related to a patient's past, present or future physical or mental condition.
 - b. health information about an individual in any form.
 - c. health information that identifies the individual.
 - d. all of the above.

 4. Name three forms of PHI protected by the Privacy Rule.
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5. My job with respect to protected health information requires me to:
 - a. do everything I can to safeguard it from unauthorized uses and disclosures.
 - b. make sure I keep it hidden from other health care providers.
 - c. cover it up whenever I am working with it.
 - d. never let a patient know what I know about his or her health condition.

6. The minimum necessary standard requires that:
 - a. I use the least amount of health information necessary to do my job effectively.
 - b. patients provide only the minimum amount of information. regarding their health status needed to treat them.
 - c. there are minimum standards for protecting patient privacy.
 - d. none of the above.

 7. The Notice of Privacy Practices:
 - a. must be read and thoroughly explained to all patients.
 - b. details how our organization uses and discloses the patient's health information.
 - c. must be carried with me at all times in case someone has a question about our privacy practices.
 - d. will probably change every few months.

 8. What is the name of the person designated as Privacy Official for this agency?
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9. Patients are informed of their privacy rights and how to exercise them:
 - a. each time they have contact with the anyone from the agency.
 - b. in the agency's Notice of Privacy Practices.
 - c. when they are upset with the care being provided to them.
 - d. all of the above.

10. The agency's privacy policies and procedures:
 - a. reflect the information provided in the Notice of Privacy Practices.
 - b. detail how the agency complies with the requirements of the Privacy Rule.
 - c. are available to all staff members to refer to as needed.
 - d. all of the above.



HIPPA Privacy Training Volunteer Certification Statement

I, _____ certify that I have received training related to the HIPAA Privacy Rule. In addition, my signature indicates that I understand my obligation, as a volunteer at this organization to abide by the agency's privacy practices, comply with federal and state laws and report any privacy breaches I discover or witness to the Privacy Official.

Volunteer's Name (please print)

Volunteer's Signature

Date

Signature of Privacy Official

Date

Please return this signed Certification Statement along with the completed attached Post Test.

Thank you!



Acknowledgement of Receipt of Notice of Privacy Practices

Dear Sheltering Arms Volunteer,

Attached is a copy of Sheltering Arms Senior Services' **Notice of Privacy Practices**. This copy is yours to keep. It is required that Sheltering Arms document that we have provided a copy of those rights to each of our volunteers. You are required to do nothing but receive this copy, but we do recommend that you read and keep it.

To help us meet **our** requirement under Federal regulations,

PLEASE PRINT AND SIGN YOUR NAME BELOW, AND RETURN THIS FORM to the address below. Your signature acknowledges only that you have received a copy of Sheltering Arms Senior Services' Notice of Privacy Practices.

Privacy Official

Sheltering Arms Senior Services
3838 Aberdeen Way
Houston, TX 77025

All Sheltering Arms' clients have also received this information. Thank you so much for your cooperation. Your support enables us to continue to provide the highest quality service to all of our clients. If you have any questions, please call our Privacy Official at **713-558-6400**.

I acknowledge that I have received a copy of Sheltering Arms Senior Services' Notice of Privacy Practices.

Printed Name of Volunteer

Signature of Volunteer

Date



Volunteer Confidentiality Agreement

I, _____, as a volunteer of Sheltering Arms Senior Services, assert that I have read and understood the Notice of Privacy Rights furnished to me by the agency. I agree to abide by the Policy of the Agency in my service as a volunteer.

I agree not to:

- reveal a Client's identity in any way, or mention a Client by name when others not involved in a Client's care may overhear.
- disclose that a person is a Client to anyone, including a Client's spouse.
- leave a Client's file unattended on my desk, or anywhere else in the workplace, at home, or wherever I perform my service.
- have files or appointment books on my desk, or wherever I perform my service, in a manner that allows a Client's name to be seen by others not involved in the Client's care.
- have a Client's information visible on a computer screen when I am away from my desk, or wherever I perform my service.
- leave computers, file cabinets, or other storage of Client information unsecured when I am not in the work area, my desk or vehicle, or wherever I perform my service.
- remove any Client files or copies from the workplace for reasons other than authorized functions.
- repeat anything a Client tells me to anyone not involved in the Client's care.
- disclose anything in a Client's file to anyone not involved in the Client's care.
- talk about a Client with anyone not involved in the Client's care, even if I do not use the Client's name.
- talk about a Client with my spouse or other members of my family or friends, unless information shared is authorized by the client or Sheltering Arms.
- give copies of anything in a Client's file to anyone not involved in the Client's care.
- retrieve messages from my voicemail or answering machine within earshot of others not involved in the Client's care.

I agree **to do** the following:

- attend/complete Privacy training as requested by Sheltering Arms.
- refer to or address Clients in the workplace in a courteous manner without the use of a Client's name when others not involved in the Client's care are present.
- keep files and appointment books face down or otherwise out of view on my desk; throughout the workplace, at home or wherever I perform my service, so that a Client's name cannot be seen by others.
- safeguard my computer password to prevent unauthorized people from accessing Client information.
- strictly comply with a Client's permission to disclose identity, confidences, or records when permission has been properly obtained in writing.
- observe all limits and conditions a Client places on any permission to disclose confidential information.
- return confidential materials at the termination of my service, or destroy them, as directed by Sheltering Arms.
- safeguard a Client's confidentiality on the receiving end of fax communications, e-mail, and telephone message-taking devices; ensure that the intended recipient is the only recipient of such communications.

Additionally,

- I will inform Sheltering Arms immediately of any and all requests I may receive for a Client's confidential information and follow directions on how to proceed.
- I will immediately inform Sheltering Arms of any accidental unauthorized disclosure of a Client's confidential information immediately.
- I will immediately inform Sheltering Arms of any information I obtain that leads me to believe that a Client may be involved in some way, directly or indirectly, in the abuse or neglect of a child, elderly person, or disabled person or if the client is the victim of abuse or neglect. I will contact Sheltering Arms at once to determine how to proceed, and follow directions.

**Sheltering Arms Senior Services
Confidentiality Agreement Acknowledgement**

I, _____, hereby acknowledge that I have read this confidentiality agreement and notice to volunteers. I understand it fully, and I will strictly follow its terms. I understand that any volunteer of Sheltering Arms Senior Services who violates a Client's confidentiality is subject to immediate dismissal.

Signature _____

Date _____