Volunteer Application

Partners In Care Maryland/CFL
Washington County Site
22 North Mulberry Street, Ste. 120
Hagerstown, MD 21740
410-544-4800 ex 27311

Contact Information

Full Name	
Street Address	
City, ST ZIP Code	
Home Phone	
Other Phone	
E-Mail Address	

Demographics

Sex: __Male __Female **Date of Birth:** _____/_____/_____ **Marital Status:**_____

Race:__ African-American __Asian __Caucasian __Hispanic __Native American Other:_____

Living arrangements: __ Alone __ With family __ With spouse __Other:_____

Monthly Income: Less than ___$1040 ___$1041-2080 ___$2081-3123 ___More than $3123

How did you hear about Partners In Care? _____

Availability

During which hours are you available for volunteer assignments? Circle all that apply.

Monday AM PM	Thursday AM PM	Sunday AM PM
Tuesday AM PM	Friday AM PM	Any Day___ Any Time___
Wednesday AMPM	Saturday AM PM	

Locations

Tell us in which areas you are willing to serve. Please check all that apply:

___ **Boonsboro** - Rohrersville, Gapland, Brownsville, Yarrowsburg, Weverton, Sharpsburg, Fairplay, Antietam, Keddysville, Beaver Creek, Mt. Lena San Mar, Mapleville, Bagtown
___ **Clear Spring** - Indian Springs, Big Pool, Pecktonville ___ **Hancock**
___ **Hagerstown** - Robinwood, Funkstown, Halfway, Chewsville
___ **Maugansville** -Broadfording, Cearfoss, Fountainhead-Orchard Hills, Williamsport, Downsvill, St James
___ **Smithsburg** - Cavetown, Mt. Aetna, Leitersburg, Highland-Cascade

Physical Limitations

Do you currently use the following? __ Cane __ Walker __ Rollator __Wheelchair __Scooter

Can you get in/out of a house by yourself? __ Yes __ No

Can you get in/out of a car by yourself? __ Yes __ No

Are you able to cook? __ Independently __ Needs Assistance

Are you able to do housework? __ Independently __ Needs Assistance

Are you able to drive or use public transportation? __ Independently __ Needs Assistance

Are you able to manage your finances? __ Independently __ Needs Assistance

Are you able to manage medications? __ Independently __ Needs Assistance

Are you able to do shopping/errands? __ Independently __ Needs Assistance

Are you able to use your phone to lookup numbers? __ Independently __ Needs Assistance

Medical Information

Do you have: __ Cancer __ Cholesterol __ Chronic Pain __ COPD__ Diabetes__ Heart Condition

__ Hypertension __ Mental Health __ Renal disease with or without dialysis __ Other_____

Are you visually impaired? __ No __ Some Vision loss __ Blind

Eye disease/condition_____

Are you hearing impaired? __ None __ Slight impairment __ Extensive Impairment

__ Wear hearing aids __ Need hearing aids

Primary Care Physician name:_____ **Phone #**_____

Medical Insurance:_____ **Secondary:**_____

Hospital of choice:_____

Self reported physical health: __ Excellent __ Good __Fair __ Poor

Are you __ Alert and orientated __ Confused/forgetful __ Significant memory loss

How often do you feel lonely? __ Hardly or never __ Some of the time __ Often

How often do you get out of the house? __ appts only __ 1-3x a week __ 4-6x a week __ Everyday

How often do you speak with friends and family? __ Not at all __ 1-3x a week __ 4-6x a week

__ Everyday

Miscellaneous

Do you have an advanced directive? __ Yes __ No Would you like more information? __ Yes __ No

Do you have an emergency response system? __ Yes __No

Would you like more information? __ Yes __ No

Do you have a working smoke detector? __Yes __ No **Would you like information?** __ Yes __ No

Miscellaneous Con't

Are you receiving services from __ Meals on Wheels __ SNAP Benefits

Are you receiving home healthcare? N or Y __ Nurse __ PT __ OT __Other_____

Do you need any services? N or Y Needed service _____

Do you smoke? Y or N

Are you Bilingual? __ No __ Yes _____

Veteran Information

Military Status: __Active __Retired __Spouse of a Veteran __Branch served and rank_____

Are you connected to the VA?_____ Why/why not_____

Are you interested in attending a Wellness Class for veterans only? Y or N

Would you like to visit Charlotte Hall? Y or N **Would you attend a Veterans Social?** Y or N

Emergency Contact

Name	
Relationship	
Street Address	
City ST ZIP Code	
Home Phone	
Other Phone	

Special Skills and Interests

Summarize special skills and qualifications you have acquired from employment, previous volunteer work, or through other activities, including hobbies or sports.

About You

What do we need to know about you in order to make a safe and effective match. (Ex. *I am very social, I don't mind multiple trips, I use a cane, I'm allergic to cats….etc)*

References (Please provide 2 references NOT related to you)

Reference #1	
Street Address	
City ST ZIP Code	
Phone	
Reference #2	
Street Address	
City ST ZIP Code	
Phone	

Membership Agreement and Signature

Please initial and sign below.

_____ I give Partners In Care/Retired Senior Volunteer Program (RSVP) permission to use my name and/or photograph in its publicity and publications.

_____ I have received and read the Volunteer Handbook and have agreed to the duties listed in the volunteer description (given at orientation).

By submitting this application, I _____ affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a member, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal. I am applying for membership and I agree to abide by all the policies and procedures of the Partners In Care Exchange program. I understand that the information contained herein is kept strictly confidential.

I understand that Partners in Care is a coordinating agency only. The staff and volunteers will refer people who state they are able to perform requested services. Partners in Care cannot guarantee the performance of anyone who is referred, nor be responsible for any injury to persons or damage to property experienced while involved in the program. The applicant hereby agrees to hold Partners in Care, as well as its employees and/or agents harmless from any and all claims or liabilities for any work performed hereunder.

Signature		PIC Staff:
Date		

Transportation Volunteers

I agree that I will use my personal automobile rendering volunteer services. I will arrange to keep in effect adequate and legal automobile liability insurance covering bodily injury and property damage so long as I use my personal automobile as part of participation in the Partners In Care program. I understand that service providers must furnish proof of a current operator's license and evidence of motor vehicle liability coverage required by the State of Maryland in the form of an insurance identification card or the front page of a current insurance policy. These documents will be photocopied and will be placed in confidential files of the Partners in Care Program.

I understand the automobile liability is not the responsibility of the Partners in Care program.

Name (printed)	
Signature	
Date	

Type of Vehicle:

_____ Compact Car
_____ Van/Small SUV
_____ Full Car/Sedan
_____ Large SUV/Truck

Tax Credit or Reimbursement:
(Choose one)
_____ ***Mileage Tax Credit***

_____ ***Gas Reimbursement***

Volunteer Opportunities Checklist

Name:_____ **Email:**_____

Please check all you are interested in:

Transportation:

___ I will transport members in my car ___ Volunteer Aid for Mobility Bus

Repairs With Care:

___ Boutique donation pickup (small items/bags)
___ Carpentry
___ Electrical, Small
___ Masonry repairs
___ Painting – necessary with a repair
___ Plumbing, small jobs
___ Technology hook-up and assistance
___ Trash removal/dump run
___ Connect America PERS installation – training provided
___ Yardwork

Help The Program:

___ Connect America Admin ___Database entry ___ Event Planning
___ Grant research/writing ___ Receptionist ___ Social Media
___ Photography for events ___ Fundraising/Marketing
___ Transportation Ride Matching ___ Transportation Intake/Data Entry
___ Translation:_____ ___ Entertainment :_____
___ Projects – calling members, email, mail and database entry
___ Program Advocacy (speaking to Civic groups and health fairs)

Boutique (AACO and Frederick)

___Cash register/POS system/baggers ___ Research of donations ___ Steaming clothes
___maintain eBay, Facebook Marketplace ___ Process donations ___ Stock shelves
___ Test electronics and small appliances ___ Staging ___ Pricing donations

Member Care:

___ De-clutter/downsize ___ Phone buddy ___ Friendly visitor

___ Reading/writing ___Respite ___ Intakes/Interviews

___ Errands/shopping (without member) ___ Crafter

___ Peer Advocacy help with advanced directives, social services, senior living

Please circle one

___ Warm Houses Participate/Assist with group

___ Learning Social/Wellness Class Participate/Assist with group

Veterans Helping Veterans:

___ Veterans Committee ___ Friendly Visits ___ Social Events

___ Veterans Driving Veterans ___ Veterans Interviewing Veterans

Professional Skills and Tasks:

___ CPA/Accounting ___ Teacher ___ Taxes

___ Case Management/Social Work ___ Notary ___ Non-Profit

___ Customer Service ___ Community Partnerships ___ Legal