VOLUNTEER PREREQUISITES

Volunteer applicant must:

1. Be receptive to all aspects of the hospice concept.

2. Complete a Volunteer Application, to include two personal or professional references.

3. Complete a Certiphi Application authorizing the hospice to request a background check.

4. Urine Drug screen required.

5. Recognize the necessity of commitment and confidentiality and sign a statement verifying agreement with this policy.

6. Two-step PPD required at time of orientation if providing care in the patient's home or in a facility, which is provided at no cost to the volunteer (proof of PPD results within the last 12 months may be accepted for one of the required tests). If unable to take the PPD, must complete Communicable Disease/ Tuberculosis Screening Questionnaire for symptom identification at time of orientation. Must also complete a Communicable Disease/ Tuberculosis Screening Questionnaire to screen for Tuberculosis annually.

7. Sign a consent/declination for the Hepatitis B vaccination. This vaccination (consisting of a series of 3 shots) is available at no cost to the volunteer if he/she chooses to receive it.

8. [illegible]

9. Be of good physical and emotional health.

10. Have reliable transportation.

11. Complete Hospice Volunteer training.

Please note: All personal information and records will be kept in a locked file accessible only to the Volunteer Coordinator/ Manager of Volunteer Services/ Director.

Applicant Signature

____

HOSPICE VOLUNTEER APPLICATION

PLEASE READ BEFORE COMPLETING THIS APPLICATION

This company does not discriminate in the recruitment, hiring, and conditions of employment *(volunteering)* on the basis of race, color, religion, national origin, sex, disability, age, or veteran status and any other applicable laws. Your completed application will be reviewed carefully. However, applying for Volunteer opportunities does not guarantee acceptance into this program. Volunteer consideration necessitates that you meet all minimum qualifications and requirements for the applied position.

PERSONAL DATA

Name ____________________ Phone/ Cell # ____________________

StreetAddress ____________________ City, State, Zip ____________________

Email ____________________

Employer ____________________ ☐Full Time ☐Part Time

Employer Address ____________________ Business Phone# ____________________

Emergency Contact #1 ____________________ Phone/Cell # ____________________

Emergency Contact #2 ____________________ Phone/Cell # ____________________

Are you over the age of 18? ☐ YES ☐ NO If NO, are you ***at least*** 16 years of age? ☐ YES ☐ NO

GENERAL INFORMATION

How were you referred to our company? ____________________

Specific name of referral source indicated *above*, if applicable: ____________________

When are you available to volunteer? ☐Weekday ☐Weekend(s) ☐SchoolYear ☐Other ____________________

Do you have access to reliable transportation? ☐ YES ☐ NO

EDUCATION

☐HighSchool ☐Associate'sDegree ☐SomeCollege ☐Bachelor'sDegree ☐Master'sDegree ☐PostGraduate ☐Other ____________________

PREVIOUS VOLUNTEER EXPERIENCE:

Organization ____________________ Type of Work ____________________

Organization ____________________ Type of Work ____________________

HOSPICE VOLUNTEER APPLICATION

REFERENCES: (Professional or personal)

Name	Address	Phone/Cell#	Relation	Time Known

VOLUNTEER POSITION PREFERRED: (Please check boxes of interest *and then* circle items of interest underneath)

***Please also provide Reference email address if possible.**

☐DIRECT PATIENT CARE

- Companionship/ socialization/ caregiver relief
- Assistance with meal preparation/ light household chores
- Spiritual/ bereavement/ emotional support
- Vigil Volunteering (sitting with and attending to our actively dying patients)
- Veteran Volunteers
- Pet therapy (requires certification of therapy animal)
- Enrichment services (music/art)

☐ADMINISTRATIVE SUPPORT (Data entry, filing, copying, assistance with mailings, etc)

☐OTHER:____

Do you speak a foreign language? ☐ YES☐NO Specify____________________

Are you an active service member/ Veteran? ☐ YES☐NO Specify____________________

Other skills and interests?____

CODE OF ETHICS FOR VOLUNTEERS

As a Volunteer, I realize I am subject to a code of ethics similar to that which binds the professional in the field in which I work. I, like them, assume accountability for my work and will seek to fulfill my responsibilities to the best of my ability. I understand that any information disclosed to me while assisting Kindred Hospice is confidential. I interpret my role as Volunteer to mean that I have agreed to work without monetary compensation. Having been accepted as a Volunteer, I will do my work according to the standards set forth in the Volunteer Orientation Manual and description. I agree to a background investigation.

DECLARATION

I hereby certify that the statements made on this application are true and correct to the best of my knowledge. I understand that by submitting this application and consenting for a background investigation I am authorizing inquiries to be made concerning my employment, character, and public records for the sole purpose of determining my suitability as a Volunteer. I affirm that I have read the Volunteer Code of Ethics and agree to abide by its regulations. I agree to respect the confidentiality of any patient or family in the course of my Volunteer activities with Kindred at Home - Hospice Division.

Printed Name____

Signature________________________________ Date________________

Hepatitis-B Vaccine Informed Consent

(To be signed and returned to your supervisor)

Hepatitis-B	Hepatitis-B is an inflammation of the liver of viral origin, usually transmitted by blood or blood products.
Hepatitis-B and Employee Health:	Hepatitis caused by the Hepatitis-B virus (HBV) is an unpredictable disease with a variety of presentations and outcomes. Perhaps 60-70% of people who are infected do not become ill. In this circumstance, prior infections can only be detected by presence of antibody in blood. On the other hand, acute symptomatic Hepatitis-B infection may result in serious liver injury which may incapacitate a person for weeks to months with approximately 5-10% of people with Hepatitis becoming chronic carriers of the virus. Death occurs in 1-2% of infected patients - either as a result of acute liver failure or chronic disease (Cirrhosis). HBV also appears to be a causative factor in the development of liver cancer. There is no effective treatment for Hepatitis-B disease.
Hepatitis B Vaccine:	Hepatitis-B vaccine is a non-infectious vaccine that affords good protection against asymptomatic infection, acute Hepatitis-B and chronic active Hepatitis, Cirrhosis, and some forms of liver cancer. (This vaccine will not prevent Hepatitis caused by other agents, such as Hepatitis-A, non-A, non-B Hepatitis viruses or other viruses known to infect the liver.) Full immunization requires three doses of vaccination over a six month period, although, some persons may not develop protective immunity even after three doses. There is no evidence that the vaccine has ever caused Hepatitis-B. The duration of immunity is unknown at this time.
Who Should Consider the Vaccine:	Hepatitis-B vaccine is indicated for susceptible individuals at increased risk for contracting Hepatitis-B infection who have not previously had clinical Hepatitis-B infection or have no detectable serum antibody to the agent.
Who Should Probably Not Take the Vaccine:	Individuals with severely compromised cardiopulmonary status (because of risk of immediate hypersensitivity reaction). It is not known whether Heptavax-B can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. Heptavax-B should be given to a pregnant woman only if clearly needed.
Possible Vaccine Side Effects:	The incidence of side effects is very low. A few persons experience tenderness and redness at the site of injection. Nausea, rash and joint pain have been reported. A low-grade fever may also occur. The possibility exists that more serious side effects may be identified with more extensive use. If you have any questions about Hepatitis-B or the Hepatitis-B vaccine, please contact your Manger.

☐ **Accept** I have read the information regarding the Hepatitis-B vaccination. I understand that I must have three doses of the vaccine to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I request that it be given to me.

☒ **Decline** I have read the information regarding the Hepatitis-B vaccination. I have been given the opportunity to be vaccinated with Hepatitis-B at no charge to myself. However, I decline Hepatitis-B vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis-B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis-B vaccine, I can receive the vaccination series at no charge to me.

☐ The office has made accommodations to provide the Hep B vaccine as indicated by the employee request.

_______________________________ _______________

Volunteer/Employee Signature Date

_______________________________ _______________

Witness Signature Date

HOSPICE VOLUNTEER PROGRAM INFORMATION

Volunteers provide emotional support and companionship, comfort, and respite to our patients and families. All of our patients have been diagnosed with a life-limiting illness and have a prognosis of 6 months or less to live. They have opted for palliative care, rather than pursuing further curative treatment. We strive to enable our patients to live their last days in the most fulfilling manner possible, whether they choose to do so in their home or in a nursing facility.

FAQs

1. **AM I QUALIFIED TO BE A VOLUNTEER?**
   Are you a good listener? Are you dependable? Do you have a desire to help others? If so, you can be a hospice volunteer. No medical experience is required. Our volunteers come from a variety of backgrounds, professions, and age groups.

2. **WHAT DO HOSPICE VOLUNTEERS DO?**
   Our volunteers serve in many capacities:
   - Administrative Volunteers assist with administrative needs in our office, including filing, photocopying, assembling information packets, assistance with mailings, making phone calls, etc.
   - Direct Care Volunteers visit our patients in their homes or in nursing facilities, providing companionship, emotional and spiritual support to patients and their families. They may provide respite care, and may also make "tuck-In calls" to our patients on a regular basis, particularly prior to weekends or holidays, to ensure that they have adequate supplies, in an effort to avoid any emergencies.
   - Bereavement Volunteers are advised by the Bereavement Coordinator and serve as an additional support to the bereavement program, which provides services to grieving families and caregivers during the 13-month period following the death of the hospice patient. Support by the volunteer may include assistance with administrative tasks (such as standard mailings), assistance with a Bereavement Support Group and/or assistance with the Annual Memorial Service. These volunteers must undergo some additional training.

3. **HOW MUCH TIME IS REQUIRED OF VOLUNTEERS?**
   Volunteers can give as much or as little time as their schedules allow. There is not a set number of hours required. As patient/family needs differ, so do volunteer hours. Whether you have a few minutes or several hours to give, this is a great program for you as it can be flexible.

4. **HOW DO I BECOME A VOLUNTEER?**
   If you'd like more information about training to serve as a hospice volunteer, please contact the hospice office and talk with the Volunteer Coordinator (VC)/ Manager of Volunteer Services (MVS). An information packet will be provided to you to read, complete and return. You will be contacted by the VC/ MVS who will answer any questions and discuss training options. Included in the packet will be a **Volunteer Application,** in which you will be asked to provide the names and contact information for two references who have known you at least one year, **Authorization for Criminal**

Background Check, and Confidentiality & Commitment Agreement which shows you are in agreement with our code of ethics and indicating you will respect patient confidentiality and pledge a commitment to our policies.

5. **WHAT IS VOLUNTEER TRAINING?**
   All volunteers must complete Volunteer Training. During your meeting with the Volunteer Coordinator, you will schedule your training, which consists of twelve (12) hours of training (to include classroom and self-study). The training will cover various topics including an overview of hospice, the volunteer program, and death and dying; listening skills; stress management; grief and bereavement; and much more. Classes are offered at various times throughout the year. You may call the office to inquire about scheduled training sessions. Training will also be tailored to individual organizations and will be provided on an individual basis.

6. **WHAT IS REQUIRED OF THE VOLUNTEERS?**
   Volunteers are encouraged to establish good communication with the Volunteer Coordinator regarding their assignments and any availability issues. Volunteers are expected to participate in at least **twelve (12) hours of required education per year**. If providing direct patient care. Volunteers must receive initial **Tuberculin Skin Test(s) (TST/PPD)**, which is provided at no charge to you, and must complete an initial and annual Communicable Disease & Tuberculosis Screening Questionnaire. In addition, volunteers are invited to attend volunteer meetings throughout the year.

If you have any questions or would like more information, please contact our Volunteer Coordinator at ________________.

DIRECT CARE
VOLUNTEER JOB DESCRIPTION

TITLE
Direct Care Volunteer

REPORTS TO
Volunteer Coordinator (VC)/ Manager of Volunteer Services (MVS)

DESCRIPTION
The Direct Care Volunteer serves as an additional support to patients and families dealing with a terminal illness and end-of-life issues. Support is provided in a variety of ways, including the provision of companionship and socialization to patients, or offering respite to stressed caregivers. Direct Care Volunteers may also make tuck in calls to patients and families. All care provided by the Direct Care Volunteer is outlined in the *Volunteer Care* Plan and agreed upon by the Interdisciplinary Group (IDG).

QUALIFICATIONS
The Direct Care Volunteer must possess the ability to actively listen and communicate compassionately with patients, families, and caregivers at the end-of-life. He/she has the ability to work as a team with family members and hospice staff. He/she must have the ability to respect patient/family belief systems, emotional maturity and sensitivity. Must be dependable and have access to reliable transportation. He/ she must have an understanding of Hospice philosophy and goals, and be willing to participate in peer support/ continuing education meetings on a regular basis. Additionally, he/ she must:

1. **Be at *least* 18 years of age**
2. Provide the following paperwork:
    a. Completed *Volunteer Application*
    b. 2 References
    c. Signed *Code of Conduct Attestation Statement*
    d. Signed Permission for Background Check
    e. Signed Permission for Drug Screen
    f. Completed *New Hire Communicable Disease/Tuberculosis/Health Screening Questionnaire* form and additional state requirements, as required
    g. *Tuberculin Test Administration Form (unless exempt from TB testing)
    h. *Completed *Hepatitis B Form*
    i. ~~Must be fully vaccinated for COVID-19~~

NOTE: * TB skin test and Hepatitis B forms are not required for volunteers only performing tuck-in calls

3. Have satisfactory references from employers and/ or professional peers
4. Have a satisfactory criminal background check (as required by state)
5. Successfully complete the Direct Care Volunteer orientation
6. Veteran Volunteers must successfully complete additional orientation specific to this role. Other specialty volunteers, such as Bereavement Support, Pet Therapy, Reiki and Vigil Volunteers must also meet requirements as indicated in those Job Descriptions.

RESPONSBILITIES

1. Provide support to patients and families by performing essential duties such as reading to patients, playing games, writing letters on behalf of patients, assisting with plant or pet care, meal preparation, companionship or support with light household chores as needed
2. Provide support to patients and families through tuck-in call processes, completes necessary forms and communicates needs/concerns to Volunteer Coordinator (VC)/ Manager of Volunteer Services (MVS) and/or IDG team.
3. May attend funeral or visit the family/ caregivers after the death of the patient
4. Participate in Volunteer support or peer groups and/ or training with other Volunteers
5. Provide availability on a regular basis and/ or keeping with the assigned patient, family and caregiver needs as outlined and defined in the *Volunteer Care Plan*
6. Maintain regular communication with the Volunteer Coordinator/ Manager of Volunteer Services about the needs of the patient, family and caregiver. Report any concerns, problems, or sudden changes in patient, family and caregiver status to the Volunteer Coordinator/ Manager of Volunteer Services ***immediately***
7. Perform duties within the established *Volunteer Care Plan* and function within authorized activities according to the individual's ability, knowledge, and training. Does not assume tasks or decisions which are outside the scope of the Volunteer or are within the domain of other persons, e.g. family, caregiver, hospice personnel or facility staff
8. Document and record hours of service and return *Volunteer Visit Documentation Form* to the Volunteer Coordinator/ Manager of Volunteer Services within a timely manner, i.e. 24-48 hours
9. Notify Volunteer Coordinator/ Manager of Volunteer Services if there is a change in situation that could affect patient care, a change in status, leave of absence or need for substitute volunteer.
10. Maintain patient, family and caregiver confidentiality and abide by federal regulations related to privacy practices, e.g. HIPAA
11. Assure for compliance with local, state, and federal laws, Medicare regulations, and established personnel policies and procedures
12. Meet or exceed delivery of Company Service Standards and operate under the company's Code of Conduct
13. Be evaluated annually based on competency and performance
14. Participate in continuing education and training, including mandatory annual in-services (HIPAA, Tuberculosis, Emergency Preparedness, etc.)

ACKNOWLEDGEMENT & SIGNATURE

I have read and I understand the description of my role as a Direct Care Volunteer, including all requirements and responsibilities. I accept the responsibility of the role of a Direct Care Volunteer and I am committed to the success of Gentiva (the Hospice). I acknowledge that I am a Volunteer of the Hospice and have no expectation of compensation now or in the future. I understand that the Hospice is required by federal Medicare regulations to utilize Volunteers in unpaid positions. I understand that I might be working side-by-side with a Hospice employee performing the same or similar tasks as I am, but for compensation. This does not confuse in any way my status as a Volunteer or my expectations for remuneration.

Signature of Volunteer Date

Printed Name Office Location

ADMINISTRATIVE VOLUNTEER
JOB DESCRIPTION

TITLE
Administrative Volunteer

REPORTS TO
Volunteer Coordinator (VC)/Manager of Volunteer Services (MVS)

DESCRIPTION
The Administrative Volunteer provides support to office personnel through clerical and administrative functions. An Administrative volunteer may assist with answering telephones, filing, making copies, data entry or helping to create admission packets. An Administrative Volunteer might help with compiling and mailing Bereavement letters, sympathy cards or the planning of the Annual Memorial Service.

QUALIFICATIONS
The Administrative Volunteer must possess strong communication skills, must be dependable, self-directed, and flexible and have the ability to work effectively as a member of a team. He/ she must have an understanding of Hospice Services and be willing to participate in peer support/ continuing education meetings. Additionally, he/ she must:

1. **Be at *least* 16 years of age**
2. Provide the following paperwork, **co-signed by a parent/ guardian if under the age of 18**:
    a. Completed *Volunteer Application*
    b. 2 References
    c. Code of Conduct Attestation Statement
    d. Signed Permission for Background Check
    e. Signed Permission for Drug Screen
3. Have satisfactory references from employers and/ or professional peers
4. Have a satisfactory criminal background check (as required by state)
5. Successfully complete the Administrative Volunteer orientation
6. ~~Must be fully vaccinated for COVID-19~~

RESPONSBILITIES
1. Assist with assigned tasks, such as, but not limited to:
    a. Answering telephone calls, taking messages, transferring calls, or making calls for staff members
    b. Organizing and compiling admission packets
    c. Copying and filing
    d. Sending, receiving, and distributing faxes
    e. Assembling Volunteer Orientation manuals and in-service packets

2. Participate in Volunteer support or peer groups and/ or training with other Volunteers to the extent necessary to comply with the training requirements imposed by federal Medicare regulations
3. Provide availability and/ or keep up with the assigned task to support office personnel
4. Maintain regular communication with the Volunteer Coordinator/Manager of Volunteer Services about any changes or concerns regarding current assignment
5. Function within authorized activities according to the individual's ability, knowledge, and training. Does not assume tasks or decisions which are outside the scope of the Volunteer or are within the domain of other persons, i.e. hospice clinical or office personnel
6. Document and record hours of service on the *Administrative Volunteer Activity Log*
7. Maintain confidentiality and abide by federal regulations related to privacy practices, e.g. HIPAA
8. Assure compliance with local, state, and federal laws, Medicare regulations, and established personnel policies and procedures
9. Meet or exceed delivery of Company Service Standards and operate under the company's Code of Conduct
10. Be evaluated annually based on competency and performance by the Volunteer Coordinator/ Manager of Volunteer Services
11. Participate in continuing education and training, including mandatory annual in-services (HIPAA, Emergency Preparedness, Ethics, etc.)

ACKNOWLEDGEMENT & SIGNATURE

I have read and I understand the description of my role as an Administrative Volunteer, including all requirements and responsibilities. I accept the responsibility of the role of an Administrative Volunteer and I am committed to the success of Gentiva (the Hospice). I acknowledge that I am a Volunteer of the Hospice and have no expectation of compensation now or in the future. I understand that the Hospice is required by federal Medicare regulations to utilize Volunteers in unpaid positions. I understand that I might be working side-by-side with a Hospice employee performing the same or similar tasks as I am, but for compensation. This does not confuse in any way my status as a Volunteer or my expectations for remuneration.

Signature of Volunteer | Date

Printed Name | Office Location/Name

VOLUNTEER NAME: ____________________________________

AVAILABILITY FOR PATIENT VISITS/VOLUNTEER HOURS

	SUN	MON	TUES	WED	THURS	FRI	SAT
TIME FRAME YOU ARE AVAILABLE							

PLEASE CHECK WHICH CITIES YOU ARE WILLING TO SEE PATEINTS IN:

- ☐ **Daytona Beach**
- ☐ **South Daytona**
- ☐ **Holly Hill**
- ☐ **Port Orange**
- ☐ **Ormond Beach**
- ☐ **New Smyrna Beach**
- ☐ **Edgewater**
- ☐ **Deland**
- ☐ **Deltona**
- ☐ **Debary**
- ☐ **Orange City**
- ☐ **Palm Coast**

VOLUNTEER
CONFIDENTIALITY &
COMMITMENT AGREEMENT

As a volunteer, I understand that I am subject to a Code of Ethics. I accept the duties and responsibilities of my position and pledge to accomplish them to the best of my ability. I am part of a unique and integrated team. My ideas and input are valuable and essential.

1. I will promise to be dependable in the performance of the responsibilities as described in the Hospice volunteer job description.
2. I will accept and follow the policies and procedures of the agency.
3. I will understand the need for and accept diversity in the workplace.
4. I will agree to an annual performance evaluation.
5. I will freely share information with my supervisor and will seek support if questions or concerns arise.
6. I will provide the Volunteer Coordinator/ Manager of Volunteer Services (VC/MVS) with appropriate information about all interactions as required by Medicare. I will submit this information/ documentation within seventy-two (72) hours of visit/ interaction, per company policy.
7. I will be a liaison between the agency and the community.
8. I will complete at least twelve (12) hours of volunteer in-service education per year.
9. If I am unable to keep my commitment, I will notify the Hospice Volunteer Coordinator.

As a Hospice volunteer, I, ______________________________, in accordance with HIPAA/agency regulations, agree to respect the confidentiality of all contacts and interactions with Hospice patients and families, and all information about patients and families conveyed by Hospice staff or through reading of Hospice medical records. I will not discuss a Hospice patient's case or mention the patient's name other than in direct contact with other members of the Hospice team.

______________________________ ______________________

Hospice Volunteer Signature Date

______________________________ ______________________

VC/MVS Signature Date

Photograph Consent and Release Form

Name: ____

I voluntarily and knowingly authorize Kindred at Home/Curo Health Services, LLC ("KAH/Curo") to take Photographs of me for publicity purposes on behalf of KAH/Curo. "Photographs" may include video or still photography, as well as related prints, negatives, computer graphics, or electronic images.

I understand that I can request that Photographs of me not be taken or used at any time; however, such request will not have any effect on Photographs that have already been taken of me and permissibly used.

I hereby give KAH/Curo the absolute right and permission to publish or otherwise use, in part or in whole, my name and any Photographs taken of me pursuant to this Release, for marketing and public relations purposes, including but not limited to: Website, Brochures/Flyers, Newsletters, and Community Outreach materials.

I acknowledge that any Photographs that are taken of me pursuant to this Release will be the sole property of KAH/Curo. I understand that I will not have the right to receive a copy, inspect, or approve any Photographs prior to the uses authorized above. I understand that consenting to permit the use of my name and Photographs is of no direct benefit to me. I waive any and all rights that I may have to any claims for payment or royalties in connection with the use and disclosure of such information and Photographs. I, along with my heirs, representatives, and beneficiaries, will hold KAH/Curo harmless from and against any claim for injury or compensation resulting from the use of my information and Photographs in accordance with this Release.

I acknowledge that if KAH/Curo discloses my information and or Photograph to a third party pursuant to my authorization, KAH/Curo has no control over how the third party uses or presents my information or Photograph. As such, I hereby release and agree to hold KAH/Curo harmless from any and all liability arising from the third party's use of my information or Photograph.

Name: ____

Signature ____ Date________________

VOLUNTEER CODE OF CONDUCT ATTESTATION

The Kindred at Home (KAH) Code of Conduct is the embodiment of our values and our dedication to integrity in the delivery of our services. It lays out the principles under which we operate and helps us put policy into practice on the job every day. It also sets forth the guidelines needed to support compliance with all federal healthcare program requirements and the provision of high-quality patient care.

To evidence that you have received, read and understand the Code of Conduct, please read the following statements below, initial each accurate statement and sign at the bottom of the page.

Statement	Initial if Agreed by the Undersigned
1) I have read the entire Code of Conduct. I have had the opportunity to ask any questions with regard to its contents, and I understand fully how it relates to my position	
2) I hereby acknowledge my obligation and agreement to fulfill those duties and responsibilities as set forth in the Code of Conduct and to be bound by those standards.	
3) I further certify that, throughout the remainder of my association with Kindred at Home, I shall continue to comply with the terms of the Code of Conduct.	
4) I understand that violations of the Code of Conduct may lead to disciplinary action, including discharge.	

______________________________ ______________________________

Volunteer Name (Please Print) Volunteer Signature

____

Date

____

Office Location

NOTE: If you wish to have a question or concern addressed before signing the above acknowledgment, please explain below. A member of the Compliance Department will contact you to discuss your questions or concerns:

____

____

____

____

PLEASE RETURN A COPY OF YOUR SIGNED ATTESTATION FORM TO YOUR SUPERVISOR.

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Kindred at Home (the "Company") may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" which may include information from a third party consumer reporting agency about you, including your character, general reputation, mode of living, employment history, academic and/or professional credentials, military service, substance use, credit history, driving history, and/or criminal history, which is used or expected to be used as a factor in establishing your eligibility for an employee and/or independent contractor position.

Under the provisions of the Fair Credit Reporting Act ("FCRA"), we must have your written permission to obtain the information described above. You hereby authorize the Company to procure report(s) on your background as described above from any consumer reporting agency contacted by the Company. You further authorize ongoing procurement of the above mentioned report(s) at any time during your employment or volunteer position with the Company.

Print Name: ______________________ **Signature:** __________________ **Date:** ______________

AUTHORIZATION AND RELEASE FOR SCREENING

I understand that I am voluntarily providing and/or giving my consent for Kindred at Home to gather information about me in connection with my employment, including but not limited to: personal identification information and documents; information and documents regarding my prior experience, qualifications, and professional licensure; criminal and other background checks; information concerning my ability to work legally in the United States; proof of required immunizations and/or health clearances; and various other information and documents related to my status as a provider of direct patient care. I further understand that from time to time, as a condition of allowing me to provide services at their facilities, health care facilities or other business partners of Kindred at Home might require that Kindred at Home release some or all of this information about me to the facility. I give my consent for Kindred at Home to share my information with these trusted business partners on an as-needed basis. I understand that should I decline to give this consent, although Kindred at Home will make diligent efforts to place me elsewhere, my hours and/or employment could be adversely affected due to the requirements of Kindred at Home's business partners and the nature of my position as a provider of direct patient care.

I authorize and request all persons, schools, business, corporations, credit bureaus, courts, law enforcement agencies, armed forces, employment commissions, and all government agencies to release requested information to Kindred at Home, Certiphi, and/or GVN without restriction or qualification. I voluntarily waive all recourse and release all such parties from liability for complying with this request/release. I understand and agree that a copy (including an electronic copy) of this Authorization will be considered as effective as the original, and I consent to receiving all documents, notices, and communications related to my application electronically.

Kindred at Home is an Equal Opportunity Employer, and does not discriminate as to race, color, gender, national or religious origin, age, disabilities or any other characteristic or activity protected by law.

I hereby declare that the answers to the questions on my application and related paperwork are true and correct to the best of my knowledge and belief, and I acknowledge that any misstatements of fact(s) or omissions may form the basis for rejection of my application or for my dismissal after employment. I further release Kindred at Home, Certiphi, GVN, and their officers, employees, and agents, from any and all liability from the results and preparation of any reports concerning my background, drug tests, or myself. I understand and acknowledge that except as provided in the Fair Credit Reporting Act, I may not bring any action or proceeding against Certiphi, Kindred at Home, GVN, or any user or furnisher of information, for any intentional tort, including defamation, or invasion of privacy, or negligence with respect to the reporting of information, except as to false information furnished with malice or willful intent to injure me.

Print Name: ______________________ **Signature:** ____________________ **Date:** _________

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

____

Employee/Contractor Name (Printed)

____

Employee/Contractor Signature

____

Date

Birthplace: ______________________

Birth Date: ______________________

Eye Color: ______________________

Hair Color: ______________________

Height: ______________________

Weight: ______________________

(Employee = Volunteer)

INFORMATION FOR PROCESSING OF BACKGROUND SCREEN REPORTS ONLY
(Not to be used for any other purpose)

As it appears on your Social Security Card: Last Name		First Name	Middle Name
City/State of Location Requesting Background Check City: State:		Position Applied For (i.e. RN, Aide, PCC):	
Date of Birth	Social Security #	Driver's License #	DL State of Issuance
Professional License Type:	License #, if applicable:	Source of Licensure:	
Male / Female / Decline to Disclose		Office Phone	Cell Phone

Current Address	Street	City	State	Zip
List all residences in the past seven years				
Prior Address	Street Zip	City	State	
Prior Address	Street Zip	City	State	
Prior Address	Street Zip	City	State	
Prior Address	Street Zip	City	State	
Prior Address	Street Zip	City	State	

STOP

Please double check your information above to ensure that all information is **legible and written** as it appears on legal documents, such as Social Security card, driver's license, etc