NYS Senior Medicare Patrol: Volunteer Application

Contact Information

Applicant Name: _____ Birthdate: _____

Address: _____

City/Town _____ State _____ Zip code _____

Primary phone: _____ Other phone: _____

Email address: _____

Best method and time to reach you: _____

Emergency contact name: _____ Relationship: _____

Primary phone: _____ Other phone: _____

Gender: ☐ Female ☐Male ☐Other ☐N/A

Race: ☐American Indian, Alaskan Native ☐Asian ☐Black or African America
☐Hispanic or Latino ☐Native Hawaiian, Other Pacific Islander ☐White
☐N/A

Do you speak any languages other than English? Please list languages:

_____

_____

Please tell us about your work experience, including paid and volunteer positions. If you are currently employed, please list your current job first. Use the remaining spaces to describe other work experiences (paid or volunteer) that relate in any way to the NYS SMP volunteer position. If you need additional space, please attach another sheet of paper.

Organization: _____

City/State: _____

Position/Title: _____

Type of work: _____

Years: _____ to _____ Role: ____ Paid employee ____ Volunteer

Organization: _____

City/State: _____

Position/Title: _____

Type of work: _____

Years: _____ to _____ Role: ____ Paid employee ____ Volunteer

NYS Senior Medicare Patrol: Volunteer Application (cont.)

Work Experience (cont.)

Organization: _____

City/State: _____

Position/Title: _____

Type of work: _____

Years: _____ to _____ Role: ____ Paid employee ____ Volunteer

Please describe any skills or experience that would enable you to perform the duties of a volunteer:

_____

Do you require any special accommodations that the NYS SMP coordinator of volunteers should be aware of? ____ Yes ____ No

If yes, please describe:

_____

_____

_____

Are you licensed and able to drive an automobile? ____ Yes ____No

If you will be driving to and from events or to conduct outreach activities, you will need to provide a copy of your driver's license and proof of insurance. We will collect this information at a later point in the screening process.

Conflict of Interest Certain conflicts between personal interests and the interests of the NYS SMP program may exist, and could prevent a person from serving as a volunteer. One example is that of a licensed health insurance agent. Some conflicts of interest, however, can be addressed in other ways and may not prevent someone from serving with the program. If you have a business or other personal interest that may create a conflict, please describe it here so we can discuss it fully during your interview.

_____

_____

NYS Senior Medicare Patrol: Volunteer Application (cont.)

Interest in the Senior Medicare Patrol Program

How did you learn about the NYS SMP program?

_____

_____

Please tell us why you would like to become a volunteer?

_____

_____

Please indicate the days and times that you are usually available.

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Saturday
- ☐ Sunday
- ☐ Morning
- ☐ Afternoon

Criminal Record Check

To ensure the safety of our clients, volunteers, and the communities we serve, applicants for certain volunteer positions will be asked to consent to a criminal records check.

Authorization and Certification

I certify that the information I provided in this application is true, complete, and accurate to the best of my knowledge. I also authorize the NYS Senior Medicare Patrol to contact the references named below with regard to my application to become a volunteer. I also authorize the persons referenced to provide information in connection with my application, and release them from any liability in regard to it.

Signature: Date:

NYS Senior Medicare Patrol: Volunteer Application (cont.)

References

Please provide three references, including at least one professional or work reference, that are not related to you and who we may contact to ask about your qualifications (if the reference is a supervisor or co-worker, please note the organization for which she or he works).

Name (first, last): _____

Phone number: _____

How long known? _____

Relationship: _____

Organization: _____

Name (first, last): _____

Phone number: _____

How long known? _____

Relationship: _____

Organization: _____

Name (first, last): _____

Phone number: _____

How long known? _____

Relationship: _____

Organization: _____

Name (first, last): _____

Phone number: _____

How long known? _____

Relationship: _____

Organization: _____

NYS SMP Conflict of Interest & Privacy Statement

I agree to the following:

I understand New York State Senior Medicare Patrol (NYS SMP) is a consumer education, assistance and advocacy service of the U.S. Department of Health and Human Services (HHS), U.S. Administration for Community Living (ACL) and the New York StateWide Senior Action Council, not a policy creating or lobbying organization.

1. NON AFFILIATION - CONFLICT OF INTEREST

I do not have an active insurance license. I will act in good faith without selling, recommending or endorsing any specific insurance product, agency, or related service. Nor am I currently affiliated with or employed by a health insurance company, agency or service, nor am I in a position to sell or receive commissions from health insurance products or services, or use my SMP affiliation for purposes of personal financial gain.

2. IMPARTIALITY

If in the future I become affiliated with an insurance company, agency or service, or I'm in a position to use my SMP affiliation for personal financial gain, I will terminate my position with the NYS SMP. Also, I will remain impartial, refraining from advising or expressing my opinions regarding a beneficiaries course of action.

3. CONFIDENTIALITY

I will not disclose any beneficiaries' personal identifying or health information to anyone outside the NYS SMP organization without the client's authorization in accordance with state and federal law.

4. NON DISCRIMINATION

I understand the act of favoritism or making a difference in treatment based on an individual's race, creed, color, religion, gender, national origin, age, sexual orientation, gender identity, expression, familial status, marital status, physical or mental disability, political party, or veteran's status is not permitted.

5. LOBBYING

I agree that I will not use public resources for political campaigns, to support or oppose candidates, ballot issues, or political causes.

Volunteer (print name) _____ Date: _____

Volunteer Signature _____ Date: _____

SMP Director _____ Date: _____

STATE WIDE
New York StateWide Senior Action Council, Inc
4 Computer Drive West, Suite 205, Albany, NY 12205 • Fax 518-436-7642
www.nysenior.org • 800-333-4374

SMP
Senior Medicare Patrol
Preventing Medicare Fraud

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PHOTOGRAPHIC CONSENT AND RELEASE FORM

I hereby authorize New York StateWide Senior Action Council, Inc. and those acting in pursuant to its authority to:

(a) Record my likeness and voice on a video, audio, photographic, digital, electronic or any other medium. (b) Use my name in connection with these recordings. (c) Use, reproduce, exhibit or distribute in any medium (e.g. print publications, video, Internet, Website, social media) these recordings for any purpose that the NY StateWide Senior Action Council, and those acting pursuant to its authority, deem appropriate, including promotional or advertising efforts.

I release NY StateWide Senior Action Council and those acting pursuant to its authority from liability for any violation of any personal or proprietary right I may have in connection with such use. I understand that all such recordings, in whatever medium, shall remain the property of NY StateWide Senior Action Council. I have read and fully understand the terms of this release.

Name: _____

Address: _____

_____

Phone: _____ Email: _____

Signature: _____ Date: _____