HOSPICE
CARE NETWORK
Experts in End-of-Life Care

Dear Prospective Volunteer

Thank you for your interest in volunteering for Hospice Care Network.

There are volunteer opportunities available assisting patients and their families or providing office support. Patient care volunteers are required to complete a 16 hour training program. Our haircutter volunteers will be given a one day training and our administrative volunteers are required to complete a two hour orientation.

After the application has been completed and returned to this office, a member of the volunteer department will contact you to make an appointment for a personal interview.

Sincerely,

Sommer Allen
Manager of Volunteer Services

Enclosures
Volunteer application
Interview questionnaire
Health assessment form

HOSPICE
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VOLUNTEER APPLICATION

Please complete each item on this application and return it to the Volunteer Office. Thank you for your interest in volunteering for Hospice Care Network.

NAME:		DATE:
ADDRESS:		BIRTH DATE: (Month/Day)
TOWN, ZIP:	HOME PHONE:	BUSINESS PHONE:
EMAIL ADDRESS:		CELL PHONE:
IN CASE OF EMERGENCY, NOTIFY:		PHONE:

Please check the appropriate box(es) for each of the following:

EDUCATION: (Please check highest level completed.)

☐ High School Graduate ☐ Professional/Technical School*

☐ College Graduate* ☐ Post-graduate* * Please specify field of study: _____

Professional license(s) held: _____

Are you currently in school? ☐ No ☐ Yes ☐ Full-time ☐ Part-time

EMPLOYMENT:

Are you currently employed? ☐ No ☐ Yes ☐ Full-time ☐ Part-time

If employed, what is your job? Please specify: _____

EXPERIENCE: What type of volunteer work have you done in the past?

☐ Health Care ☐ Teaching ☐ Business ☐ Trade ☐ Other: (Please specify): _____

Have you had any experience with groups (such as support groups or self-health groups)?
☐ No ☐ Yes – Please specify: _____

SKILLS: What are your special skills and/or hobbies?

☐ Nursing ☐ Teaching ☐ Notary ☐ Music/drama ☐ Hairdressing ☐ Computer

☐ Public Speaking ☐ Typing/office skills ☐ Other: Please specify: _____

Do you speak/understand a foreign language? ☐ No ☐ Yes Please specify: _____

PERSONAL EXPERIENCE:

Have you experienced any deaths in your family or of those close to you? ☐ No ☐ Yes

If yes, what was your relationship with the person and when did they die?

VOLUNTEER INTERESTS:

☐ Patient/family volunteer ☐ Watchman volunteer ☐ Hairstylist

☐ Office (clerical and or computer) volunteer ☐ Speakers' Bureau

☐ Pet Therapy ☐ Special Events

TIME AVAILABLE: Mon Tues Wed Thurs Fri Sat Sun

	Morning	Afternoon	Evening
Weekdays	_____	_____	_____
Weekends	_____	_____	_____

TRANSPORATATION:

Do you drive? ☐ Yes ☐ No

Do you have a car at your disposal? ☐ Yes ☐ No

Please list two references who are not you relatives:

Name: _____Phone: _____

Address: _____Town: _____Zip: _____

Name: _____Phone: _____

Address: _____Town: _____Zip: _____

How did you hear of Hospice Care Network?

_____

_____

Signature: _____ Date: _____

If you are applying to become a patient care volunteer, please read and sign the following statements:

As a Patient Care Volunteer I will abide by the following requirements:

1. I will be available to take cases, hours may range from 2-4 hours with one or more patients weekly._____
   (initial)
2. I will be able to drive within thirty minutes from my home to make visits._____
   (initial)
3. I will be able to sit with patients who may not be responsive or be able to verbalize feelings in order to provide respite for family members of caregivers._____
   (initial)
4. I will be able to update my coordinator on a weekly basis either by phone or email, regarding the outcome of the visit that did or did not take place so they can report information at team meetings. _____
   (initial)
5. I will send in the necessary documentation for patient care visits on a weekly basis. _____
   (initial)
6. I will attend a yearly mandatory in-service and complete all necessary documentation. _____
   (initial)

7. I will complete the annual evaluation, health assessment and PPD annually and on time. _____
(initial)

8. I will commit that my agenda will be to support the patient and family and not have a personal agenda for visits. _____
(initial)

9. I will be flexible in accepting assignment where I am needed most. _____
(initial)

HCN VOLUNTEER SERVICES
INTERVIEW QUESTIONNAIRE

Name:_____ Date:_____

Please answer the following questions so we may consider your needs.

1) What is your understanding of Hospice care?

2) What experiences have you had with people who are seriously ill?

3) What personal experiences have you had with loss and death?

4) How did you become interested in Hospice work?

5) What do you feel you can offer Hospice patients and families?

6) Does your spouse/family support your being a Hospice volunteer?

_____
Volunteer Coordinator

TO: All Volunteers

FROM: Sommer Allen
Manager of Volunteer Services

RE: Requirements for Volunteers

The following documentation is required of volunteer applicants in order for Hospice Care Network to be in compliance with all regulations. These papers are needed prior to the beginning of the training classes for patient care volunteers and Haircutter volunteers and prior to starting an assignment as an administrative volunteer.

1. Initial Health Assessment form (to be completed by your physician)

2. Proof of Immunity to Rubella (If born before 1/1/57).

3. Volunteers born on or after January 1, 1957 need proof of MMR (measles, mumps and rubella) immunity. This requires a lab report.

4. Proof of Mantoux test (PPD) for tuberculosis. In accordance with the Dept. of Health regulations, a 2-step process is necessary for PPD test. If you have not had a PPD test within the past 12 months, you are required to have a second PPD within 1 to 3 weeks of the first test.

5. Proof of Varicella Immunity

6. Original passport or current driver's license and original social security card.

7. Cosmetology License (if applying for the haircutting program)

If you have any questions, please call the Volunteer Office Monday through Friday, 8:30-4:30 at 516-224-6416. If you live in Queens, you may call 718-746-6142, extension 404. Your cooperation is appreciated and we look forward to welcoming you as a volunteer with Hospice Care Network.

HOSPICE CARE NETWORK

INITIAL HEALTH ASSESSMENT FORM

[ ] Employee [ ] Volunteer

Name_____

Address_____

Date of Birth_____

The above named person has been examined by me and has completed the required tests and immunizations:

Results

Rubella Antibody Titer (attach lab report) _____

Rubella Immunization (if non-immune) _____

PPD Mantoux Skin Test _____

Date Administered: _____

Date Read: _____

Chest X-Ray (attach report) _____
(If PPD positive)

MMR(Rubeola, Mumps and Rubella –
(If born after 1/1/57, required to have 2 MMR vaccinations
30 days apart – attach lab report) Date #1_____
Date #2_____

Varicella Immunity (attach lab report) Date: _____

and is able to perform the tasks of employee/volunteer, which may include:

Traveling, stair climbing, lightweight carrying, assisting caregiver in providing services to a patient and light household tasks.

Comments:

1. May perform all tasks as stated: _____

2. May perform tasks with limitations: (State limitations)

_____

_____

_____

_____

_____ Date:_____
Physician's Signature

_____ Date:_____
Medical Director's Signature