

**Bent County HealthCare Center
Youth Volunteer Application**

Name: _____ Birth date: _____

Address: _____ City: _____ Zip Code: _____

Phone #: (home) _____ (cell) _____

Email Address: _____

Emergency Contact

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Relevant Physical Limitations: _____

Volunteer Interests: _____

Preference of Days and Times to Volunteer: _____

Start Date: _____

TB Immunization: _____

*Volunteers with 4 hours or more/month are required to get a TB test

Volunteer Signature/Date

Activity Director/Coordinator's Portion:

- Review of volunteer application _____ (date & initial)
- Review of volunteer policy packet _____ (date & initial)
- Tour of facility _____ (date & initial)
- Volunteer orientation completed _____ (date & initial)
- Introduction to Elder Council President _____ (date & initial)

**Bent County HealthCare Center
Activities Confidentiality Statement**

By my signature below, I certify the following and agree to abide by the facility's policies and procedures/privacy rules regarding confidentiality, release and access to the elders' personal and protected health information. I understand this information includes any information about the elders of this facility regardless of the source of that information (verbal, written or electronic) and this includes both personal as well as any medical/financial information.

I agree to keep all elder information confidential and will not discuss, release or tell any other persons inside or outside of the facility except to authorized staff/persons as consistent with my role as a volunteer of this facility.

I have been informed and understand the limitations of my role as a volunteer of this facility and will not take, read, copy or write down any information from the elders' medical/financial record unless I have been authorized to do so in adherence with applicable HIPAA regulations and facility policies.

I understand this information is protected by Federal and State regulations and laws and that my breach of confidentiality/unauthorized release whether verbal, written, electronic or release of copies may result in sanctions imposed by the facility, which can include warnings, suspensions, termination of my position, civil lawsuits and reporting of the infraction to State and Federal authorities who can impose fines and prison terms.

I understand release of elder protected health information is for the purpose of treatment of the elder. Information can also be released to obtain payment for services provided and for required health care operation or with elder consent. Release will be within the privacy rules/standards and policies and procedures established by this facility, which includes HIPAA (Health Insurance Portability and Accountability Act) standards for my job or role as a volunteer.

Signature of Volunteer

Date

Bent County HealthCare Center
Activity Program Interests

Please check all the activities you may be interested in assisting with.

Group Programs:

- Arts and Crafts
- Exercise Group
- Active Games (Dominoes/Board Games/Cards)
- Birthday Celebrations
- Holiday Parties
- Gardening/Greenhouse
- Outings (Shopping/Concerts/Fishing)
- Bingo
- Reading Groups
- Men's Club
- Lady's Club
- Evening Movies, etc
- Religious Activities

Independent Choices:

- Resident Store (Kountry Kupboard)
- Musical Performances
- Newspaper Reading
- Mending
- Pet Therapy

One-to-One Visits

- Conventional Visits
- Letter Writing
- Tables Games/Cards
- Outdoor Rides/Walks
- Reading Aloud/Talking Books

Volunteer Name

Date

**Bent County HealthCare Center
Youth Volunteer Consent Form**

I, _____, parent/guardian of _____
hereby give my consent for my son/daughter to participate in the youth volunteer program for Bent County
HealthCare Center. I understand that my son/daughter will provide (_____) hours* of service per week and will
participate in only the following activities:

In the case of an emergency, please contact:

- | | |
|--------------------|---------------|
| 1. Name _____ | Phone # _____ |
| Relationship _____ | |
| 2. Name _____ | Phone # _____ |
| Relationship _____ | |
| 3. Name _____ | Phone # _____ |
| Relationship _____ | |

Signature, Parent/Legal Guardian	Date
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*Those who volunteer 4 hours or more per month are required to get a TB test.