VIRGINIA
HOME HEALTH
& HOSPICE

V A H H H ®

VOLUNTEER APPLICATION

7061 West Lee Highway
Rural Retreat, VA 24368
Office: 276.686.6321
Fax: 276.686.6160
ruralretreat@vahhh.com

Name:

Address: _____

Home Phone: _____ Date of Birth IF UNDER 18 YEARS OF AGE: _____/_____/_____

Occupation: _____ Work Phone: _____

Emergency Contact: _____ Emergency Phone: _____

E-mail address: _____

Are you retired? ❑ Yes ❑ No

How were you referred to Virginia Home Health & Hospice?

❑ Employee ❑ Media ❑ Health fair ❑ Personal experience (self, friend or family received services)

❑ Other _____

Do you have a valid driver's license? ❑ Yes ❑ No; If yes, driver's license number: _____

Do you have a clean driving record? ❑ Yes ❑ No

Do you have a care at your disposal? ❑ Yes ❑ No

Do you have personal liability limits on your auto insurance? ❑ Yes ❑ No
You will be required to provide Virginia Home Health & Hospice a copy of your Personal Liability Insurance. ***Insurance information will need to be updated each year. Along with TB, Confidentiality forms and license every 4 years)***

Car Insurance Company: _____ Phone: _____

Have you been convicted of any violation of the law since your 16th birthday, other than minor traffic violations? If yes please explain: _____

_____

_____

_____

_____

Is religion meaningful to you? ❑ Yes ❑ No; Please indicate on scale of 1-4 what degree it is meaningful _____
(1 = LITTLE MEANINGFUL - 4 = VERY MEANINGFUL)

Would you be comfortable discussing spiritual issues with clients? ❑ Yes ❑ No

If you wish to, tell us what church you attend and where it is located:

Church: _____ Location: _____

Please check those areas in which you are interested or willing to help:

- ❑ Caregiver Relief
- ❑ Visiting Nursing Home Patients
- ❑ Small Repair Work
- ❑ Perform Sign Language
- ❑ Occasional Meal Preparation
- ❑ Transportation for Appointments
- ❑ Reading to Patients
- ❑ Writing Letters for Patients
- ❑ Fundraising Events
- ❑ Bereavement Visits
- ❑ Office Skills
- ❑ Community Education
- ❑ Hospice Singers
- ❑ Speak Foreign Language: _____
- ❑ Other: _____

What is your primary reason for wanting to become a Virginia Home Health & Hospice Care volunteer: _____

_____

_____

Would you be willing to work with a patient with an infectious disease such as hepatitis, AIDS, etc.? ❑ Yes ❑ No

Please list preference of days of week, and particular time of day you would be available to volunteer: _____

_____

_____

Briefly describe your special interest, hobbies, skills or talents: _____

_____

_____

Do you have any previous volunteer experience? ❑ Yes ❑ No; If yes, please list most recent experience below:

Name of Organization: _____

Responsibilities: _____

Length of service: _____ Date last volunteered: _____

Are you currently a volunteer with any agency? ❑ Yes ❑ No; If yes, please list the current agency below:

Name of Organization: _____

Responsibilities: _____

Briefly describe your education and work experience. Any life experience you wish to share will also be welcomed:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Due to the nature of certain Virginia Home Health & Hospice Care volunteer assignments, references may be required. Please provide the name and address of two individuals:

Name: _____ Phone: _____

Address: _____ Years Acquainted: _____

Name: _____ Phone: _____

Address: _____ Years Acquainted: _____

If applying as a patient care volunteer, please read and complete the additional information.

Patient Care volunteers are required to complete an orientation program by Virginia Home Health & Hospice. Hospice volunteers must complete a 4-hour training program prior to working with Hospice patients.

Are you willing to participate in the required training within the coming year? ❑ Yes ❑ No

What would you like to learn in the orientation and training? _____

_____

_____

Briefly describe your strengths in working with others: _____

_____

_____

What situations might challenge you in visiting patients and families? _____

_____

_____

Have you experienced the death of a family member or close personal friend in the past 5 years? ❑ Yes ❑ No

Explain time relation and time frame (i.e. – experienced death of father, 1 year ago) _____

_____

_____

I understand that this information, which I have provided, will be kept confidential and available only to the Directors of Virginia Home Health & Hospice and those designated by them for selection and training of volunteers. This information was requested in order to determine your experience, availability, motivation and needs for volunteering. I agree to sign a **Criminal Record Release Form** and a **Confidentiality Statement** and abide by it when participating as a Home Health and Hospice Care Volunteer. If I am choosing to work as a direct care volunteer, I understand that initial TB testing is required. Yearly testing is required for all active volunteers participating in patient care.

I hereby certify that this application contains no willful misrepresentation or falsification and that the information given by me is true and complete to the best of my knowledge and beliefs. I am aware that should investigation at any time disclose any such misrepresentation or falsification, my application will be dismissed from the service of **Virginia Home Health and Hospice**.

Signature: _____ Date: _____