



TRI-COUNTY COMMUNITY ACTION AGENCY
Henry • Oldham • Trimble

VOLUNTEER APPLICATION

Revised 6.22



VOLUNTEER APPLICATION

Name: _____

Address: _____

Phone numbers: _____

Birthdate: _____ Email address: _____

Education/Special Training: _____

Have you ever been convicted of a felony? NO YES

Please explain: _____

Why would you like to volunteer at TCCAA? _____

How did you hear about us? _____

Which volunteer opportunities interest you? Please refer to next page for a list of roles:

Which counties (Oldham, Trimble, Henry) are you open to working in? _____

Which weekdays are you available? _____

In the case of an emergency, who might we contact?

Emergency contact name (+ relationship): _____

Contact's phone number and address: _____

Please **sign**: _____ Date: _____



VOLUNTEER OPPORTUNITIES

- **Adult Daycare Assistant:** Help with daily activities, arts & crafts, serving meals and snacks, and help keeping track of personal items.
 - **Adult Daycare Chaperone:** Enjoy a short trip to help daycare clients & staff with walkers, getting on and off a bus, and serving a meal or snack.
 - **Commodities:** 3rd Tuesday of each month help arrange food pallets into 50 family boxes, put boxes in vehicles (able to lift about 40 lbs.) and remove trash.
 - **Counseling:** Use your Master's degree to provide direction for depression and grief.
 - **Friendly visiting:** Help to put a smile on a homebound senior's face by spending some time with them in their home to develop friendships and keep them from feeling isolated.
 - **General office duties:** Help keep things organized around our center by filing paperwork, and helping out the staff.
 - **Kitchen help:** Package foods to be delivered as frozen or warm meals. Prepare lunch trays for the senior center.
 - **LIHEAP:** November - April low income heating assistance program, and also when funds are available for summer cooling; sign-in clients & manage groups, pull folders, check paperwork, make copies and file folders.
 - **Meal delivery:** Use your vehicle to deliver warm or frozen meals to homebound seniors once a week, once a month or more often.
 - **Receptionist:** Warmly greet visitors, answer phones, and keep things organized.
 - **Senior Center Assistant:** Help with daily activities, arts & crafts, serving meals and snacks, and providing companionship.
 - **TeleCare:** Call from your home (or the center) to check on an assigned group of homebound seniors at a given time to make sure they are doing well.
 - **Transportation driver:** Use our vehicles to pick up or drop our clients at the center, or to pick up or drop off clients with scheduled medical appointments such as dialysis.
 - **Fundraising!** We need all the help we can get.
 - **Publicity!** Do you have PR or social media skills?
 - **Cleaning.** Do you have organizational and cleaning skills?
 - **Other...** Tell us your idea.
-
- ❖ Training is provided for all positions.
 - ❖ State regulations require a criminal background check on all volunteers.
 - ❖ All Henry, Oldham and Trimble county residents over the age of 60 (and their spouses, regardless of their age) are invited to apply for free senior services, including a hot lunch and use of our facilities.
 - ❖ TCCAA is funded, in part, under a contract with KIPDA through KY CHFS with funds from HHS, Metro United Way, Community Block Service Grant (CBSG) and other matching funds and grants.



PROHIBITED VOLUNTEER ACTIVITIES

Volunteers are prohibited from involvement in any of the following activities:

- Seeking or accepting personal gifts and/or favors of a significant value (\$25 or more) from a client.
- Operating a client's personal vehicle.
- Borrowing money or personal property from a client.
- Loaning or accepting money from or on behalf of a client.
- Consuming or taking a client's belongings.
- Charging TCCAA programs for time spent on political activities.
- Being under the influence of intoxicating beverages, drug(s) or chemicals, other than those prescribed by a licensed healthcare practitioner.
- Transporting a client using KIPDA funds without program authorization.
- Performing financial management for a client including, but not limited to, completing tax returns, banking business, balancing check books, issuing and/or cashing personal checks, acting under a power of attorney, selling and/or buying personal or real estate property, unless specifically funded and/or approved by KIPDA.
- Accepting payment for services performed for a client that would normally be provided by a family member (such as, receiving payment from a service provider for providing respite services to a parent).
- Violating client confidentiality by revealing client information.
- Participating in any illegal, unethical or unprofessional behavior with a client.
- Taking part in client referrals or other client transactions if a conflict of interest, real or apparent, exists. A conflict of interest occurs when a volunteer or family member has a financial or other interest in any of the competing firms.
- Committing theft of a client's belongings, including prescription drugs.
- Administering prescription or over-the-counter medication to a client.

With the exception of Licensed Home Health Agencies and Adult Day Health Models (prescribed in 902 KRS 20:066), the following procedures shall not be performed:

- Performing tasks that require sterile techniques.
- Administering enemas, or any fluids to intravenous (IV) lines, Foley catheters or ostomies.

Volunteer Signature: _____ Date: _____



VOLUNTEER CONFIDENTIALITY

I, _____ (volunteer name), understand I may be allowed access to confidential information and records to perform my volunteer duties. I understand and agree I am not to disclose confidential information and records without the prior written consent of the client and approval from the Executive Director.

I understand that accessing or releasing confidential information and records, or causing confidential information and records to be accessed or released to myself, clients, relatives, other individuals, etc. outside the scope of my assigned volunteer duties would constitute a violation of this agreement. This may result in disciplinary action, termination of my access to information and/or my services.

Confidential information shall include but is not limited to:

- Activities I observe or participate in through agency sponsorship.
- Verbal or written information to which I have access that pertains to clients, staff, volunteers, agencies, or committees.

I understand other types of information may also be protected by confidentiality, and when in doubt as to its confidentiality status, I shall not release any information before determining if the information may be disclosed.

I agree to:

- Maintain confidential information;
- Utilize information disclosed to me solely for the purpose of providing and enhancing services provided by TCCAA;
- Restrict the disclosure of protected information only to TCCAA staff and as I am instructed by my supervisor.
- Report as required by law, any suspected cases of child or adult abuse, neglect or exploitation.

By signing this document, I acknowledge I have been informed of the relevant laws and regulations concerning access, use, maintenance, and disclosure of confidential information and records. I further agree to maintain the confidentiality of information that has been issued to me in confidence, even after my volunteer services with TCCAA have ended.

I have read and understand my responsibilities as related to maintaining confidentiality.

Volunteer Signature: _____ Date: _____



VOLUNTEER AGREEMENT & KY WORKER'S COMP.

I, _____ (volunteer name), agree to the following regarding volunteering and worker's compensation coverage.

→ performing volunteer services for TCCAA.

→ TCCAA providing worker's compensation coverage to me for any injury sustained during the performance of volunteer services on behalf of TCCAA.

→ TCCAA providing full coverage pursuant to the Kentucky Worker's Compensation Act (KRS 342, et seq.) to the extent authorized by law.

→ accepting the coverage of the Worker's Compensation Act as the sole remedy for any damages I may suffer from any and all services performed for TCCAA.

Volunteer's Signature: _____ Date: _____

Volunteer's TCCAA Supervisor: _____ Date: _____

For volunteers under the age of 18, a parent or legal guardian must sign to acknowledge acceptance of this agreement.

Parent/Guardian's Signature: _____

Minor's age: _____



HIPAA NOTICE of PRIVACY PRACTICES

(Effective on/after August, 1, 2015)

This notice explains how **Tri-County Community Action Agency (1015 Dispatchers Way, LaGrange, KY 40031)** may use and reveal your protected health information to provide you services, obtain payment and for other purposes that are permitted or required by law. It also explains your right to use and be in charge of your protected health information. "Protected health information" is any information about you, including information that may identify you or connects to your past, present or future physical or mental health and associated services.

Uses and Disclosures of Protected Health Information (PHI). Your PHI may be used and revealed by your service provider, our personnel or any others outside the agency who are involved in your care for the purpose of providing services to you, to pay for your services, to support the operations of TCCAA, and any other use as permitted or required by law.

Services: We will use and reveal your PHI to provide, coordinate, or manage your services. This includes cooperation with a third party such as, but not limited to, a hospital ambulance or doctor.

Payment: Your PHI may be used, as needed, to obtain payment for your services. This includes cooperation with a third party such as, but not limited to, your insurance company, worker's compensation provider, or a collection agency.

Operations: We may use or reveal your PHI, as needed, in order to support the business activities of TCCAA. These activities include, but are not limited to, quality assessment, employee review and improvement, training, licensing, marketing, fundraising, or statistical data documentation. For example, your PHI will be seen where you sign your name on arrival, your name may be called out-loud or posted related to activities, or may be seen by a student training in our facility.

We may use or reveal your PHI in the following situations **without** your authorization as permitted or required by law: communicable diseases, public health, health oversight, the FDA, legal proceedings, law enforcement, abuse or neglect, coroner, organ donation, funeral director, criminal activity, inmates, military activity, national security, or worker's compensation. Under the law, we must tell you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted or required use and disclosure of your PHI will be done only with your consent, authorization, or opportunity to object unless required by law.

You may **revoke this authorization** at any time, in writing, except to the extent that TCCAA has taken an action on the use or disclosure indicated in the authorization.

Your Rights regarding Your Protected Health Information (PHI)

- 1. You have the right to receive a paper copy of this notice.**
- 2. You have the right to inspect and copy your PHI.** However, you may **not** inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, or PHI that is subject to law that denies access to PHI.
- 3. You have the right to receive certain disclosures we have made of your PHI, if any.** We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as stated in this notice.
- 4. You have the right to request a restriction of your PHI.** This means you may ask TCCAA not to reveal any parts of your PHI for purpose of services, payment, support operations, or any others. Your request must state the specific restriction requested and to whom you want the restriction to apply. TCCAA is not required to agree to a restriction that you may request, if we believe it is in your best interest to permit use and disclosure of your PHI. You then have the right to use another service provider. You have the right to request confidential communications from us by an alternative means (such as a FAX), or at an alternative location.
- 5. You may have the right to have your PHI modified.** If your request is denied, you have the right to file a Statement of Disagreement with the HIPAA Compliance Officer for TCCAA. We have the right to prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Complaints

You may complain to the HIPAA Compliance Officer for TCCAA or the Secretary of Health and Human Services if you believe your privacy rights have been violated by the agency. We are not permitted to take action against you for filing a complaint.

Your signature is only requested to indicate that you have received this HIPAA Notice of Privacy Practices.

Volunteer Signature: _____ Date: _____

TCCAA Supervisor Signature: _____ Date: _____



CRIMINAL BACKGROUND CHECK AUTHORIZATION

Full Name: _____

DOB: _____ Social Security No.: _____

Maiden Name or Aliases: _____

Current Address: _____

I, _____ (volunteer name), hereby authorize TCCAA to conduct a police/criminal investigation into my background. I realize this check is a routine procedure to ensure the safety of the clients I may be serving. At this time, I am stating I have never been convicted of a criminal offense that would disqualify me for the position for which I am applying and that a routine criminal background will verify this information. If the criminal background check reveals information to the contrary, I realize that my involvement with TCCAA will be declined.

Volunteer Signature: _____ Date: _____

TCCAA Office Use

Mailed date: _____ Mailed by: _____

Date results released: _____ Is volunteer eligible? _____

Comments: _____



VOLUNTEER PRE-TRAINING QUESTIONNAIRE

Volunteer Name: _____ Date: _____

Please circle the correct answer:

1. **Most people who abuse adults are:**

- a. Paid caregivers
- b. Not related to the victim
- c. Adult children of the victim
- d. Spouse of the victim

2. **In Kentucky, if you suspect elder abuse you have no legal responsibility to report it:**

- a. True
- b. False

3. **Neglect only occurs when:**

- a. a caregiver can no longer take care of a person.
- b. a person cannot take care of themselves.
- c. when a person is over or under medicated
- d. all of the above

4. **Adult Protective Services (APS) is a voluntary service:**

- a. True
- b. False

5. **Most people will become ‘senile’ sooner or later if they live long enough:**

- a. True
- b. False

6. **Clinical depression in older adults is:**

- a. common when they lose their spouse to death.
- b. when there is a continued need for deep sleep.
- c. an expected change in the aging process.
- d. all of the above.
- e. none of the above.

7. **How many older adult visits to physicians result in a new or refilled prescription?**

- a. 25%
- b. 75%
- c. 80%
- d. 40%

8. **Early-onset alcoholic misusers:**

- a. Begin drinking in their mid to late 30’s.
- b. Make up about two-thirds’s of all older adults with alcohol use disorder
- c. Are more likely to be male.
- d. All of the above

9. **Late-onset alcohol misusers:**

- a. Are referred to as reactive drinkers.
- b. Represent about 1/3 of older adults with drinking problems.
- c. Are likely to be women.
- d. All of the above

10. An active listening statement would be:

- a. “You are not listening to me.”
- b. “It sounds like you are very worried about your health.”
- c. “I don’t understand what you are telling me, say it again.”
- d. “Please speak louder, I can’t hear you.”

11. A close-ended question/statement would be:

- a. “What is your name, and please spell it”
- b. “How did that make you feel?”
- c. “I imagine you enjoy being with your grandchildren.”
- d. “It sounds like you have some questions about our program.”

12. A suicide warning is:

- a. A person talking about wanting to go to sleep and never wake up.
- b. A person giving away prized belongings.
- c. None of the above.
- d. A and B.

13. If a person does not answer your question immediately, you should keep talking to fill in the silence:

- a. True
- b. False

14. You may call the Crisis and Information Center for assistance and information about various situations only between 9 am – 5 pm weekdays.

- a. True
- b. False

15. The Kentucky Planning and Development Agency (KIPDA) is the designated Area Agency on Aging for the following counties: Bullitt, Jefferson, Oldham, Shelby, Spencer, and Trimble:

- a. True
- b. False

16. What local agency is the primary funding source for the nutrition program for the elderly, which includes senior center and nutrition site meal programs and the home-delivered meal program?

- a. Louisville Metro Government
- b. Metro United Way
- c. KIPDA
- d. American Red Cross
- e. None of the above

17. The Area Agency on Aging Services Network includes which of the following services:

- a. Counseling
- b. Health promotion services
- c. Meals on Wheels
- d. Transportation
- e. All of the above

18. The Older Americans Act is the law that established the Area Agency on Aging and the Foundation Aging Services Network that exists throughout the country:

- a. True
- b. False

Thank you!



VOLUNTEER TRAINING LOG

Name: _____

Date of Training: _____

Location: _____

TCCAA Trainer: _____

Topics Completed:

- New volunteer orientation
- Policies and procedures
- Job description
- Confidentiality
- Worker's compensation

Volunteer Signature: _____ Date: _____

Trainer Signature: _____ Date: _____