



HOME DELIVERED MEALS (HDM) VOLUNTEER APPLICATION

OFFICE USE ONLY!

____/____/20____
Today's Date

Last 4 of Social Security

- ## - ____

VOLUNTEER INFORMATION

Last Name

First Name

Middle Initial

Suffix (Dr., Jr., Sr.)

____/____/____
Date of Birth

Preferred First Name / Nick Name

RESIDENTIAL/MAILING ADDRESS

Is your postal/mailling address exactly the same as the residential address? ☐ No ☐ Yes

Street Address

City

PA
State

Zip

PO Box If Applicable

Municipality/Borough/Township

(____)____-____ ☐ Home ☐ Cell
Primary Phone #

(____)____-____ ☐ Home ☐ Cell
Secondary Phone #

Email Address

EMERGENCY CONTACT INFORMATION

Physician's Name / Practice

(____)____-____
Phone

Street Address

#1 Emergency Contact Name

(____)____-____
Phone

Relationship

#2 Emergency Contact Name

(____)____-____
Phone

Relationship

APPLICATION QUESTIONNAIRE

1) What is your gender? Please Select ONLY ONE! ☐ Female ☐ Male

2) Marital Status: Please Select ONLY ONE! ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

3) What is Your Ethnicity? Please Select ONLY ONE!

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

4) What Is Your Race? Please Select ONLY ONE!

☐ American Indian/Native Alaskan	☐ Native Hawaiian/Other Pacific Islander	☐ Unknown/Unavailable
☐ Asian	☐ Non-Minority (White, non-Hispanic)	☐ Other _____
☐ Black/African American	☐ White-Hispanic	

5) Are you Employed? ☐ Full-Time ☐ Part-Time ☐ NOT Employed

If Employed: Place of Employment: _____ Co. Phone

6) Do you have a valid driver's license? ☐ YES ☐ NO

7) Is your vehicle available for your own transportation? ☐ YES ☐ NO

8) Do you have auto insurance that covers passengers riding in your car? ☐ YES ☐ NO

9) Do you have physical limitations? ☐ YES ☐ NO

If YES, Please List: _____

REFERENCES

(Please list two (2) personal references who have known you for at least one (1) year)

#1 Reference Name

#2 Reference Name

How do you know this person? (Co-Worker, Friend, etc.)

How do you know this person? (Co-Worker, Friend, etc.)

(____) ____ - ____
Phone

(____) ____ - ____
Phone

#1 Reference Address

#2 Reference Address

SKILLS

Please list any special or unique talents, and/or specific skills you are willing to share with us.

ATTACH A COPY OF DRIVER'S LICENSE / STUDENT ID / VEHICLE REGISTRATION & INSURANCE

☐ **By checking this box:**

I understand that, as a volunteer, I will help the agency to the best of my ability and will maintain complete confidentiality concerning all information on clients and/or agency.

X _____
Volunteer Signature (Type Full Name) Date



NORTHEASTERN SENIOR COMMUNITY CENTER

“HOME AWAY FROM HOME”

HIPPA LAW UPDATES

The York County Area Agency on Aging notified Senior Community Centers of HIPPA law(s) that affects the confidentiality of our members and home-delivered meals consumers. The law is explained below and we are asking for your signature after you have read, understood and will abide by the confidentiality issue.

Confidentiality Issues

Health Insurance Portability and Accountability Act of 1996 (HIPPA)

Public Law 104-191-signed on August 21, 1996 – based on the Kennedy-Kassebaum bill.

Primary Goal:

Make it easier for people to keep health insurance and help the industry control administrative costs.

Components

Title I Health Insurance Portability

Title II is designed to Reduce Health care fraud and abuse

Guarantee security and “privacy” of health information

Enforce standards for health information and transactions

Title III Tax Related Provisions

Title IV Application and Enforcement of Group Health Plan Requirements

Title V Revenue Offsets

Effective Date

October 16, 2002 for Electronic Data Transfer and April 14, 2003 for Privacy.

Privacy Rule

Gives people more control over their health information

*Sets boundaries on the use and health care providers and others must achieve to “protect privacy” of health information. Holds violators accountable with civil and criminal penalties that can be imposed if person’s rights are violated. It strikes a balance when public responsibility requires disclosure of some forms of data- for example to protect the public health.

Protected health information

Includes individually identifiable health information that is transmitted electronic media, maintained in any electronic media, transmitted or maintained in any other form (including oral or written).

Two concepts:

Consent – A person’s written consent before using or disclosing their personal health information to carry out treatment, payment or health care operations.

Authorization – More customized document that gives the provider permission to use the information for other specific purposes, for example for a research project.

Penalties

Civil - \$100 per violation up to \$25,000 per year for multiple violations

Criminal - \$50,000 fine, one year in prison or both. If under False pretenses \$100,000 fine, five years in prison or both. If under Criminal Intent to sell, transfer \$250,000 fine, ten years in prison or both.

How are you affected?

Responsibilities to maintain privacy as Business Associates of YCAAA.

I have read the above HIPPA law and understand that as a volunteer I will be expected to maintain consumer” confidentiality.

X _____
Volunteer Signature (Type Full Name) Date