



# Volunteer Application Package



LOCAL HELP FOR PEOPLE WITH MEDICARE



April, 2016

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**Georgia Department of Human Services  
Division of Aging Services  
GeorgiaCares Program**

Dear Volunteer:

Thank you for your interest in GeorgiaCares, a volunteer-based program that provides free, unbiased and factual information and assistance to Medicare beneficiaries, their families, and caregivers. GeorgiaCares is the State Health Insurance Assistance Program (SHIP) and the Senior Medicare Patrol (SMP). We are here to help people with Medicare understand their choices, get the most out of their healthcare benefits, enroll in a Medicare plan that meets their needs, and assist with and educate on how to prevent, detect, and report health care fraud, error, and abuse through outreach, counseling, and education.

Volunteers are essential to the work of the GeorgiaCares Program. They assist with administrative tasks, distribute information promoting and marketing community awareness about Medicare, staff information booths at outreach events, make presentations, conduct outreach events, educate people about Medicare plans and benefits, help people who have questions about health care fraud and abuse, and much more.

GeorgiaCares provides thorough orientation, training, supervision and ongoing support for its volunteers to enable them to carry out the tasks of their respective positions as they work to fulfill the GeorgiaCares Program mission.

We want you to have a positive and productive volunteer experience. The work is challenging, interesting, and ultimately rewarding. Please take a few moments to review the other materials in this packet. To apply for a volunteer position with the GeorgiaCares Program, complete the enclosed application forms and return them to the coordinator. If you have any questions about the volunteer program or the application and screening process, please feel free to call us at **1-866-552-4464 (Option 4)**.

Without volunteers, the program could not function, so we gratefully appreciate your interest and look forward to hearing from you.

Respectfully,

GeorgiaCares Coordinator



**Become a GeorgiaCares PEACH Pal:**

As the aging population continues to grow, volunteers are needed now more than ever. GeorgiaCares' volunteer program is called **PEACH** Pals. Volunteer roles are open to community members of all ages above the age of majority regardless of gender, disability, race, or other condition. All volunteers are asked to commit to at least six (6) months. Training and support is provided prior to official duty. The program operates with five standard volunteer roles. Information about the roles and the responsibilities connected with them are set forth in position descriptions. It is important to know that the screening process and training requirements are more demanding for those roles identified as "positions of trust." A position of trust is one in which a volunteer has access to another person's protected personal, health care, or financial information.

**Please check the box (you can check more than one) next to the description of the GeorgiaCares volunteer roles that most interest you:**

- Partner Volunteer/Distributing information:** Under the direct supervision of local coordinator, this role involves transporting and disseminating SHIP and SMP information materials to sites and events, and may include presenting prepared copy or performing scripted activities for small groups. Volunteers will promote and market community awareness of health insurance information; fraud, errors, and abuse of Medicare; and assistance and referral services provided by GeorgiaCares. Volunteers who work in this role do not engage in discussions with others about personal information or situations. This role is not considered to be a position of trust.
  
- Educator Volunteer/Making group presentations:** Under the direct supervision of local coordinator, this role involves giving substantive presentations on the Georgia- Cares program topics such as goals of GeorgiaCares, changes in Medicare, current issues affecting people with Medicare, and fraud and abuse of Medicare to small and large groups, with the opportunity for interaction with the audience during time set aside for Q & A and discussion. This role is a position of trust.

- Administrator Volunteer/Assisting with administration:** Under the direct supervision of local coordinator, this role involves maintaining overall organization and administration for the local GeorgiaCares program such work as copying, filing, data entry, and placing outbound phone calls in support of SHIP and SMP activities. Volunteers who work in this role do not take inbound phone calls or field questions from the public. This role is not considered to be a position of trust.
  
- Counselor Volunteer/Counseling:** Under the direct supervision of local coordinator, this role involves direct discussion with beneficiaries about health insurance options, assistance and appropriate referrals to Medicare beneficiaries and their families, discussion about their individual situations which may include review of personal information such as Medicare Summary Notices, billing statements and other related financial and health documents. This role is a position of trust.
  
- Hero Volunteer/Staffing exhibits:** Under the direct supervision of local coordinator, the primary role and responsibility of a hero volunteer is to conduct outreach events for GeorgiaCares program which include staffing information kiosks or exhibits at events such as health fairs. Volunteers who staff exhibits provide general information about SHIP and SMP to the public and answer simple inquiries. This role is a position of trust.



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### Contact Information

Applicant name: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Primary phone: \_\_\_\_\_ Secondary phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Best method and time to reach you: \_\_\_\_\_

Emergency contact person name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Primary phone: \_\_\_\_\_ Secondary phone: \_\_\_\_\_

### Demographic Information

DOB: \_\_\_\_\_

<p><b><u>Disability Status</u></b></p> <p><input type="checkbox"/> Disabled</p> <p><input type="checkbox"/> Not Disabled</p> <p><input type="checkbox"/> Not Collected</p> <p><b><u>Gender</u></b></p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Not Collected</p>	<p><b><u>Race/Ethnicity</u></b></p> <p><input type="checkbox"/> American Indian or Alaska Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> Hispanic or Latino</p> <p><input type="checkbox"/> Native Hawaiian or other Pacific Islander</p> <p><input type="checkbox"/> White, not of Hispanic origin</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Not Collected</p>
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## Applicant Information

1. Educational level: \_\_\_\_\_  
Completed High School       Some College       College/University: \_\_\_\_\_
  
2. Do you speak any languages other than English? Please list language(s):  
\_\_\_\_\_  
\_\_\_\_\_
  
3. Do you have any medical conditions that may affect your ability to function as a GeorgiaCares volunteer, or do you require any special accommodations that the GeorgiaCares coordinator of volunteers should be aware of?       Yes       No  
If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_
  
4. Have you ever been convicted, pled no contest, or pled guilty to a felony or misdemeanor?  
\*Note: To ensure the safety of our clients, volunteers, and the communities we serve, all applicants for volunteer positions will be asked to consent to a National Record check. We will ask you to complete a separate form to authorize a criminal record check.  
\_\_\_\_\_  
\_\_\_\_\_
  
5. Please describe any skills, training, experience and interests that would enable you to perform the duties of a GeorgiaCares volunteer.  
\_\_\_\_\_  
\_\_\_\_\_
  
6. Please tell us about your work experience, including paid and volunteer positions.  
*If you are currently employed, please list your current job first. Use the remaining spaces to describe other work experiences (paid or volunteer) that relate in any way to the SMP volunteer position. If you need additional space, please attach another sheet of paper.*
  - A. Organization: \_\_\_\_\_  
City/State: \_\_\_\_\_  
Position/Title: \_\_\_\_\_  
Type of work: \_\_\_\_\_

Years: \_\_\_\_\_ to \_\_\_\_\_

Role:  Paid employee  Volunteer  Other

B. Organization: \_\_\_\_\_

City/State: \_\_\_\_\_

Position/Title: \_\_\_\_\_

Type of work: \_\_\_\_\_

Years: \_\_\_\_\_ to \_\_\_\_\_

Role:  Paid employee  Volunteer  Other

C. Organization: \_\_\_\_\_

City/State: \_\_\_\_\_

Position/Title: \_\_\_\_\_

Type of work: \_\_\_\_\_

Years: \_\_\_\_\_ to \_\_\_\_\_

Role:  Paid employee  Volunteer  Other

7. Certain conflicts between personal interests and the interests of the GeorgiaCares program may exist, and could prevent a person from serving as a GeorgiaCares volunteer. One example is that of a licensed health insurance agent. Some conflicts of interest, however, can be addressed in other ways and may not prevent someone from serving with the GeorgiaCares program. If you have a business or other personal interest that may create a conflict, please describe it here so we can discuss it fully during your interview.

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### Interest in the GeorgiaCares Program

1. How did you learn about the GeorgiaCares program?

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2. Please tell us why you would like to become a GeorgiaCares volunteer?

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3. Please indicate your availability by placing an X in the appropriate day and time slots:

*\* The only volunteer work conducted on the weekends includes health fairs and enrollment events.*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

### Authorization and Certification

I certify that the information I provided in this application is true, complete, and accurate to the best of my knowledge. I also authorize the GeorgiaCares program at the Division of Aging Services to contact the references named below with regard to my application to become a GeorgiaCares volunteer. I also authorize the persons referenced to provide information in connection with my application, and release them from any liability in regard to it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## References

Please provide three references, including at least one professional or work reference, that are not related to you and who we may contact to ask about your qualifications (if the reference is a supervisor or co-worker, please note the organization for which she or he works).

A. Name (first, last): \_\_\_\_\_

Phone number: \_\_\_\_\_ How long known? \_\_\_\_\_

Relationship: \_\_\_\_\_

B. Name (first, last): \_\_\_\_\_

Phone number: \_\_\_\_\_ How long known? \_\_\_\_\_

Relationship: \_\_\_\_\_

C. Name (first, last): \_\_\_\_\_

Phone number: \_\_\_\_\_ How long known? \_\_\_\_\_

Relationship: \_\_\_\_\_



## Code of Ethics Agreement

As a GeorgiaCares volunteer, I realize that a code of ethics applies to my work, similar to that which binds the paid professional staff in the organization. In agreeing to serve, I assume certain responsibilities and expect to account for my actions in terms of these professional expectations. I will honor the GeorgiaCares program goals and abide by its rules and regulations. I recognize and adhere to the following points of volunteer ethics and will endeavor to:

1. Keep confidential matters confidential, including all matters related to the operation of the GeorgiaCares program and all information regarding beneficiaries.
2. Stay informed regarding changes in GeorgiaCares program and confidentiality policy (including HIPAA standards) to effectively safeguard program and beneficiary privacy.
3. Participate fully in training according to the standards and practices of the program.
4. Participate in efforts to maintain and promote the integrity and credibility of the program.
5. Recognize the boundaries of my own level of training/skills and consult with appropriate staff when needed.
6. Maintain competence in relevant areas.
7. Provide services with respect for human dignity unrestricted by considerations of age, social or economic status, personal characteristics or lifestyle choices.
8. Act in accordance with the standards and practices of the GeorgiaCares program and with respect to the policies of the sponsoring organization.
9. Avoid any conflict of interest or appearance of conflict of interest, including financial gain, in the provision of services.
10. Not sell or endorse any insurance policy or financial service product as a volunteer for the program and am not currently employed as an insurance agent.

I will do my utmost to uphold this Code of Ethics, as I understand the effectiveness and credibility of this program depends, in part, on the way I carry out my responsibilities.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Volunteer Agreement

I, \_\_\_\_\_, a GeorgiaCares volunteer, agree to do the following as part of my participation:

1. to perform activities as assigned;
2. to provide unbiased counseling as it relates to the various program components;
3. to rigorously adhere to Volunteer Confidentiality Agreement;
4. to make referrals to appropriate agencies as specified in the Program Manuals and/or other procedural guidance provided by DHS Division of Aging Services;
5. to maintain required forms, logs and reports;
6. to provide appropriate monthly data and reports to the GeorgiaCares Coordinator in a timely manner;
7. to participate in required training, attending at least 3 in-service trainings per year; and
8. to educate/inform individuals and groups about GeorgiaCares at every opportunity.

### The GeorgiaCares Coordinator agrees:

1. to provide training and technical assistance;
2. to furnish all forms, revised/updated reports and materials as they become available;
3. to supply volunteers with current materials; and
4. to formally recognize the contribution of the GeorgiaCares volunteers annually.

It is understood that the DHS Division of Aging Services **does not** provide automobile liability coverage. Therefore, we expect that you will not provide transportation to the Medicare beneficiaries. It is mutually agreed and understood that you are an independent volunteer and not an employee, agent, partner or independent contractor or otherwise engaged in a joint venture with the DHS Division of Aging Services or any contracting agency under this agreement.

A copy of this agreement will be given to you upon signature. The GeorgiaCares Program Coordinator will retain the original.

Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Volunteer Rights and Responsibilities

As a GeorgiaCares Volunteer you have the right to:

1. Be treated with respect.
2. Receive meaningful assignment.
3. Appropriate orientation and ongoing training.
4. Effective training and direction.
5. Grievance without threat of retribution.
6. Be heard as an agency team member.
7. Recognition for your volunteer efforts.
8. A safe and professional atmosphere in which to work.
9. Be notified of changes or termination of your volunteer assignment.

As a GeorgiaCares Volunteer you have the responsibility to:

1. Adhere to host agent policies.
2. Perform duties effectively and alert coordinator if assignment is unsatisfactory.
3. Attend meetings and trainings provided for volunteers.
4. Ask questions when training or direction is unclear.
5. Speak up when things are not right.
6. Speak out in a constructive and effective manner.
7. Give input as to how you wish to be recognized.
8. Report safety hazards and unprofessional behavior in a professional manner.
9. Be honest and notify coordinator when needs change or ability to volunteer changes.

By signing below, you are certifying that you have read and understand your rights and responsibilities as a GeorgiaCares Volunteer.

Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## **The GeorgiaCares Program’s Obligation to Protect Confidentiality**

The GeorgiaCares program considers its responsibility to protect the privacy and confidentiality of its clients of great importance. The GeorgiaCares volunteers share in the responsibility to maintain the confidentiality of all privileged information to which they have access and must take all steps necessary to prevent personal and internal GeorgiaCares program information from falling into the hands of unauthorized persons. This responsibility includes but is not limited to the following types of information regarding beneficiaries:

1. Names
2. Date of birth
3. Address
4. Social Security Number
5. Contact information
6. Medical information
7. Reason for contacting the SHIP and/or SMP program

The GeorgiaCares volunteers are obligated to protect the confidentiality and privacy of all clients’ records and information disclosed to them in the course of their duties, pursuant to state and federal law and regulations, DHS and DAS policies related to privacy and confidentiality, including Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The GeorgiaCares program also occasionally handles complaints against providers. These, too, involve sensitive information that should be protected. Complaints of fraud, error, and abuse are considered “potential” or “suspected” fraud, error, and abuse. Thus, GeorgiaCares does not accuse providers of fraud, error, or abuse. In some circumstances, GeorgiaCares research and follow up with providers may be sufficient to determine if a billing error occurred. However, only an investigation by the proper authorities can substantiate claims of fraud and abuse.



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### The GeorgiaCares Volunteer’s Commitment to Protect Confidentiality

I understand that as a GeorgiaCares volunteer I will have access to information regarding the SHIP and SMP programs operation, their partners, and beneficiaries. I agree that I:

1. Have read the “The GeorgiaCares Program’s Obligation to Protect Confidentiality” (attached) and understand its purpose to protect information related to their operations, partners, and beneficiaries, and I accept my responsibility to abide by this obligation, pursuant to state and federal law and regulations, DHS and DAS privacy and confidentiality policies, including Health Insurance Portability and Accountability (HIPAA) of 1996.
2. Will maintain strict confidentiality of the GeorgiaCares program information, including all personal, sensitive or private information regarding beneficiaries, partners, other clients, providers, GeorgiaCares programs operations, and agencies acting on behalf of any person seeking help for problems under these programs.
3. Will discuss GeorgiaCares beneficiary or internal GeorgiaCares program information only with other volunteers or staff members, and then only as appropriate or necessary to fulfill my role as a volunteer.
4. Will conduct all conversations with clients with the utmost privacy, away from others who could overhear confidential information.
5. Will not mention the name or other details about beneficiaries, providers, or other GeorgiaCares clients in conversation with people outside of GeorgiaCares.
6. Will safeguard written or electronic information about individual beneficiaries and providers.

I understand that breach of confidentiality is very serious and carries with it the possibility of disciplinary action, including dismissal.

Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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### Driver’s License and Insurance Coverage Certification

Please check only the box that applies regarding your driver’s license and insurance information:

I, (print volunteer's name) \_\_\_\_\_, certify that I have a valid driver’s license and current automobile insurance coverage. I agree to provide a current copy of both my driver’s license and automobile insurance for my record. In the event that my automobile insurance policy lapses, I agree to notify my GeorgiaCares Coordinator immediately.

I pledge that if I drive my own vehicle on behalf of GeorgiaCares, adequate insurance will always be in force; and I also understand that as a volunteer driver, the limits and coverage provided by my personal automobile insurance are applicable to any accidents or incidents that involve my vehicle, including those that occur while I am serving as a volunteer driver for GeorgiaCares.

I, (print volunteer's name) \_\_\_\_\_, certify that I do not have a driver’s license or automobile insurance coverage at this time and will not operate an automobile vehicle myself while I serve as a volunteer for GeorgiaCares. I agree to notify the GeorgiaCares Coordinator if I obtain a driver’s license and provide a current copy of both my driver’s license and automobile insurance for my record upon receipt.

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Verification of Insurance Agent License Status

Effective April 1, 2015, GeorgiaCares staff and volunteers must certify that they do not have an active license to sell any type of insurance. This includes, but is not limited to; Life, Personal Accident, Medical, Health, Vehicle, Home, Travel, Burial, Crime, Political Risk, Workers Compensation, Disability, Liability, and Resident Surplus Line.

GeorgiaCares does not employ staff or accept volunteers with active licenses to sell insurance. GeorgiaCares staff and volunteers do not sell, endorse or wish to give the appearance of endorsing any insurance products.

GeorgiaCares is a trusted source of information about Medicare and health related insurance. GeorgiaCares provides free, unbiased and factual information at one-on-one counseling sessions and during outreach and education events for Medicare beneficiaries, family members and caregivers.

I hereby give my consent to GeorgiaCares to verify that I do not have an active license to sell insurance of any type. GeorgiaCares will verify my status with the Georgia Office of Insurance and Safety Fire Commissioner (OCI). An agent search will be conducted on the OCI website and/or a call placed to the OCI to verify the records are accurate. The search will occur annually. GeorgiaCares reserves the right to conduct agent searches more often to protect the integrity of the program and Medicare beneficiaries.

I understand that if I do not agree to an agent search, it is grounds for immediate dismissal as a volunteer from the program. Potential volunteers with active licenses will not be accepted. GeorgiaCares staff with active licenses may be reassigned to another position within the Area Agency on Aging (AAA) or the Georgia Legal Services Program (GLSP).

GeorgiaCares Staff or Volunteer

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_





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### Volunteer Term of Work Agreement

I, [insert volunteer's name] \_\_\_\_\_, agree to volunteer as a [insert name of volunteer role] \_\_\_\_\_ with the [name of agency or organization] \_\_\_\_\_.

I have been informed of and oriented to my volunteer duties. I pledge to perform these duties to the best of my ability, not to undertake tasks beyond the duties assigned to me, and to ask for direction from my supervisor whenever I have questions about my role. I understand that the GeorgiaCares Program reserves the right to make changes in my volunteer assignment and that it accepts my service with the understanding that this volunteer service exists at the sole discretion of the GeorgiaCares Program. My term with the GeorgiaCares Program is one year and will be reevaluated as needed.

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_