**New Volunteer Checklist**

- o Volunteer Application
- o Copy/picture of front of Driver License

- o Background Check Release Forms:

_____ Level 2 (fingerprinting)

- All Sunshine Center volunteers
- Volunteers who help clients complete state/federal paperwork
- Volunteers who work with clients and serve > 20 hours/month

_____ Level 1 (all other volunteers)

- o $20 donation toward background screening fees:

Cash, credit card or check made payable to COA
(designate background check in memo line)

To schedule your volunteer appointment, please
contact Pat Herndon, Volunteer Coordinator
Volunteer@coasjc.org
904-209-3686

*(No walk-in appointments are available.)*

**180 Marine Street**
**St. Augustine, FL 32084**
**(904) 209-3700 • Fax (904) 209-3654**
**Volunteer Office (904) 209-3686**

# VOLUNTEER INFORMATION SHEET

Name: _____

Address: _____

_____ Zip: _____

Birth Date: _____ Driver's License # _____
*(Please provide a copy of D.L.)*

Phone #: _____ Cell #: _____ Work # _____

E-Mail address: _____

Emergency Local Contact: _____ Emergency Phone # _____

Employment History & Volunteer Experience/Areas of Interest: _____

_____

_____

_____

List Any Physical Limitations _____

Languages Spoken: _____

Days Available: _____ Time Available: ____ a.m. ____ p.m.

I understand that if I use my personal automobile in my volunteer service, I will agree to keep in effect automobile liability insurance equal to the minimum required by the State of Florida. Furthermore, I understand that I am not an employee of the Council on Aging.

_____ _____
Signature of Volunteer Date

**********FOR OFFICE USE**********

*Volunteer Assignment:* _____

*Volunteer Schedule:* _____

*Revised November 9, 2017*

**Volunteer Guidelines for**
**HIPAA Privacy Laws**

Federal law under HIPAA, the Health Insurance Portability and Accountability Act of 1996, mandates that every individual has a right to the privacy and security of their protected health information (PHI). This includes the kind of information that volunteers may encounter while working in the Memory Enhancement Program. The following guidelines will ensure that all volunteers remain complaint with HIPAA privacy laws.

***Who must comply with HIPAA regulations?***

Any organization dealing with personal health information; it is called a covered entity. The Council on Aging is a covered entity.

***What kind of health information is protected under HIPAA?***

PHI includes any information that can be linked to a specific individual, such as: name, address, employer, relatives' names, date of birth, telephone number, email address, social security number, medical record number, and job information. PHI also includes financial and health information that can be linked to a specific individual, such as: billing information, insurance coverage, illness description or diagnosis, medications, tests and test results, observations about the individual's condition, past health conditions or treatment, discharge planning, and genetic information.

***How does a COA volunteer comply with HIPAA requirements?***

Only those people with an authorized "need to know" to perform their jobs may have access to PHI. HIPAA requires healthcare workers to use and share or release only the minimum necessary information to perform their jobs without compromising patient care. Before viewing PHI or releasing it to someone, ask yourself if you really need the information to perform your job or does the other person need it to perform his or her job.

***What are some examples of HIPAA violations?***

1. Sharing a participant's PHI with any individual who does not need to know it, like another participant or a COA volunteer who does not work with the participant.
2. Gossiping about or discussing participant's PHI anywhere at any time.
3. Sharing a participant's PHI with your friends or family members.
4. Mentioning to your friends, family or coworkers that an individual is attending the Memory Enhancement Program.
5. Sharing PHI information that you accidentally overhear.
6. Leaving a participant's PHI out in plain view where other people can see it.
7. Sharing PHI with a participant's friends or family members without that participant's permission.

Protecting participant's privacy and security is a federal law with penalties. The COA expects all volunteers to diligently adhere to HIPAA policies.

I, _____(print name), have read the above HIPAA guidelines and agree to abide by them at all times.

Signed_____ Date_____


# CONFIDENTIALITY AGREEMENT

Print Full Name _____

1. I agree that I will not disclose the identity of any clients or any information concerning clients to anyone except COA staff.

2. I understand that the records and communication received by the Council on Aging in the course of this work is strictly confidential and as volunteer personnel, I assume primary obligation and responsibility to safeguard information concerning clients.

3. When I leave a volunteer position at the Council on Aging, I promise to keep confidential any and all sensitive information I have gained through my work as a Council on Aging volunteer.

DATE: _____

SIGNATURE OF VOLUNTEER: _____

SIGNATURE OF VOLUNTEER COORDINATOR: _____

# OPEN-DOOR GRIEVANCE POLICY

Volunteers are encouraged to express their volunteer-related concerns to their supervisor, and it is hoped that all concerns can be resolved satisfactorily through informal and open communication.

Grievances must be submitted *in writing* to the Volunteer Manager, or to the Operations Director if the grievance is against the Volunteer Manager.

Volunteers may request assistance with the grievance procedure.

Final action on any grievance submission will be taken within 10 working days. Your signature below represents your commitment to abide by all volunteer policies.

_____ _____

Volunteer Date

# Authorization and Release

Medical Express Corporations is acting as a clearinghouse for **background** information as described in the following Authorization and Release.

I hereby authorize without condition, except as provided for under the provisions of the Fair Credit Reporting Act (FCRA) any vendor or agency contacted by Medical Express to provide personal and private information pertaining to my driving record which may contain records concerning accidents, traffic violations and certain criminal offenses.

I understand that I have the right to make a written request to Medical Express for additional information concerning any report obtained on my behalf. I understand that I am within that right to dispute the accuracy of any information contained in said record either by mail or in person at the address of Medical Express Corporation, 4237 Salisbury Road, Suite 304, Jacksonville, Florida 32216.

I hereby authorize the below named company in conjunction with Medical Express Corporation to conduct this investigation as set forth in the above.

**St. Johns County Council on Aging: (Please Print)**

First Name _____ Middle _____ Last Name _____

Social Security Number _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Volunteer's Signature _____ Date _____