



ADULT VOLUNTEER APPLICATION FORM

First Name	Middle Name	Last Name
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How do you want your name listed on your nametag (first name only):

Address	City, State	Zip
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Phone (Home)	Phone (Work)	Date of Birth (mm/dd/yy)
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Cell Phone	E-Mail Address
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Emergency Contact

Name	Phone	Relationship
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Location & Schedule Preference

<input type="checkbox"/> St. Paul Home <input type="checkbox"/> St. Paul Villa <input type="checkbox"/> Community Outreach <input type="checkbox"/> St. Paul Hospice	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <hr/> Preferred Times	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday	<input type="checkbox"/> Saturday <input type="checkbox"/> Sunday
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What hobbies, skills and interests would you like to share with residents/SPES?

Why do you want to volunteer at St. Paul Elder Services?

Please indicate your education and training?

Please indicate your occupation and employer contact information (if retired, please indicate previous work experience).

Occupation (type of work)	
Current or last employment:	
Employer's Name:	Dates of employment:
Employer Address:	Phone Number:
City/State:	Zip Code:
May we contact your employer: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please provide two (2) personal references: Must be 21 years old and not a member of your family:

Name:	Phone:
Address:	Relationship to you:

Name:	Phone:
Address:	Relationship to you:

VOLUNTEER OPPORTUNITIES

ACTIVITY PROGRAMS

- Arts and Crafts
- Exercise
- Gardening with Residents
- Manicures
- Music (play instrument)
- Painting Class
- Singing
- Writing Class

GENERAL

- Baking/Cooking
- Companion for Doctor Appointments
- Ladies or Men's Club
- Outdoor Rides/Walks
- Pet Therapy
- Reminiscing and/or Reading
- Transport wheelchairs (in facility)
- 1:1 Visiting

GAMES

- Bingo
- Cards (bridge, poker, sheep head, etc.)
- Table Games

OTHER

- Clerical Work
- Gift Shop
- Mail Delivery
- Mending
- Computer (IT)
- SPOON (assisting residents with eating)

HOSPICE

- Patient Support
- Bereavement Services
- Administrative/Clerical

MAINTENANCE

- Clean storerooms
- Cleaning Vehicles
- Grounds work – mowing, weeding, raking, planting
- Painting

SPECIAL SERVICE

- Power washing
- Staining
- Clean/arrange Comfort Carts
- Shredding paper

DIETARY

- Stainless steel cleaning (kitchen)
- Clean refrigerators

RELIGIOUS PROGRAMS

- Caring Companion (read bulletin or visit)
- Companion for the Dying
- Eucharistic Minister at Mass
- In Room Communion
- Lector at Mass
- Lutheran Services
- Assist with Music during Liturgy
- Rosary

HEALING WATERS POOL

- Teach Classes (CPR required – water safety preferred)

MEALS ON WHEELS (MOW)

- Driver

CLUB GABRIEL (ADULT DAY SERVICES)

- Driver/Transport (outings)
- Assist with Activity Programs
- Music/Play Instruments/Sing

SPECIAL DUTIES

- Community Outings
- Dances
- Holiday Parties
- Musical Performances
- Concierge (Greeter at receptionist desk)
- Paul's Pals (hospitality on neighborhood)

CLINICAL DUTIES (must be an RN)

- Blood Pressure
- Blood Sugar
- Immunizations (giving shots)
- Foot and Nail Care

HOUSEKEEPING/LAUNDRY

- Washing windows (day rooms/Haen/life enrichment)
- Spotting carpets
- Clean vents, light fixtures, etc.
- Wipe down garbage cans
- Wipe down Dining room chairs
- Wash walls (Dining room)
- Organize supply room
- Assist in Laundry
- Stock Linen

NURSING

- Wipe down wheelchairs (in facility)
- Wipe down equipment (lifts/walkers etc.)
- Wipe down railings (hallways)
- Clean bed frames

THERAPY

- Transportation

Confidentiality Statement:

I will consider as confidential, all information which I may gain in my volunteer position, directly or indirectly, concerning patients, doctors, staff, employees, families, and volunteers. I understand that my volunteer service may be curtailed as a result of any breach of confidentiality. I certify that information given herein is true and complete to the best of my knowledge. I understand that I am applying for a volunteer position, without promise of expectation of compensation. I understand that my position can be terminated with or without notice, at any time, at either the option of the volunteer or St. Paul Elder Services. These policies are subject to changes as deemed necessary.

Applicant Signature:

Date:

If you are interested in volunteering in Hospice, the following information also needs to be completed. Thank you.

Hospice Areas of Interest:

☞ Patient Care Volunteer

Provides direct support to patients and families through companionship, assisting with tasks, and errands:

- In Home
- In Nursing Home
- In Assisted Living
- Personal Care
- Meal Preparation/Delivery
- Alternative Therapies
- Companionship

☞ Bereavement Volunteer

Provides ongoing emotional and spiritual support by visits, calls, or letters:

- Caller
- Home Visits
- Support Group Co-Facilitator
- Memorial Service Committee

☞ Administrative Volunteer

Provides assistance with office tasks, special functions, and projects:

- Clerical/Office
- Fundraising
- Mailings
- Events
- Marketing
- Courier
- Receptionist
- Data Entry
- Transportation

Do you know a language other than English?

Language: _____ Speak Read Write

Language: _____ Speak Read Write

How did you hear about our Hospice program?

Why do you want to be a Hospice Volunteer?

(continued on back)

Death and Dying

What are your thoughts and feelings about death and dying?

Have you ever been with and/or cared for someone at the time of their death? Yes No

If yes, please describe briefly: _____

What qualities (skills, talents, knowledge, and experiences) do you feel you can incorporate into your hospice volunteer work with someone who is dying?

When thinking of your own death, what words best describe death to you?

- | | | | |
|------------------------------------|---------------------------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sorrowful | <input type="checkbox"/> Natural | <input type="checkbox"/> Frightening | <input type="checkbox"/> Painful |
| <input type="checkbox"/> Lonely | <input type="checkbox"/> Joyful | <input type="checkbox"/> Heavy | <input type="checkbox"/> Peaceful |
| <input type="checkbox"/> Dark | <input type="checkbox"/> I do not think of my own death | | |

If you'd like to explain: _____

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS

- **PENALTY:** A person who provides false information on this form may be subject to forfeiture and sanctions, as provided in Wis. Stat. § 50.065(6)(c) and Wis. Admin Code § DHS 12.05(4).
- Completion of this form to verify your eligibility for employment/service as a “caregiver” is required by Wis. Stat. § 50.065 and Wis. Admin Code ch. DHS 12. Failure to complete this form may result in denial or termination of your employment, contract or service agreement.

Refer to DQA form [F-82064A, Instructions](#), for additional information.

Check the box that applies to you.

- Applicant / Employee

 Student / Volunteer
 Contractor

 Other – Specify:

NOTE: This form should NOT be used by applicants for *entity operator approval* (license, certification, registration or other DHS approval) or by entities requesting approval for an individual to reside in entity facilities as a *non-client resident*. Applicants for *entity operator approval* or for a *non-client resident* background check must request an [entity background check](#) from the Division of Quality Assurance.

Full Legal Name – <i>First</i>	<i>Middle</i>	<i>Last</i>
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Other Names (including prior to marriage)

Position Title (applied for or existing)	Birth Date (MM/DD/YYYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Home Address	City	State	Zip Code
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Business Name and Address – Employer (Entity)

Answering “NO” to all questions does not guarantee employment, a contract, or service agreement.

If more space is required, attach additional documentation to this form and indicate “see attached” in your answer.

SECTION A – DISCLOSURES

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?
If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.
You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
3. Please note that Wis. Stat. § 48.981, *Abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect.
Has any government or regulatory agency (other than the police) ever found that you committed **child** abuse or neglect?
Provide an explanation below, including when and where the incident(s) occurred.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected **any person or client**?
If **Yes**, explain, including when and where it happened.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

- | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------|
| <p>5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client?
If Yes, explain, including when and where it happened.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>6. Has any government or regulatory agency (other than the police) ever found that you abused an elderly person?
If Yes, explain, including when and where it happened.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?
If Yes, explain, including credential name, limitations or restrictions, and time period.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |

SECTION B – OTHER REQUIRED INFORMATION

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------|
| <p>1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services?
If Yes, explain, including when and where it happened.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility?
If Yes, explain, including when and where it happened and the reason.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>3. Have you been discharged from a branch of the US Armed Forces, including any reserve component?
If Yes, indicate the year of discharge:
Attach a copy of your DD214, if you were discharged within the last three (3) years.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>4. Have you resided outside of Wisconsin in the last three (3) years?
If Yes, list each state and the dates you resided there.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years?
If Yes, list each state and the dates you resided there.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>6. Have you had a caregiver background check done within the last four (4) years?
If Yes, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe?
If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |

Read and initial the following statement.

I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

<p>NAME – Person Completing This Form</p>	<p>Date Submitted</p>
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