



**BALTIMORE COUNTY DEPARTMENT OF AGING
VOLUNTEER REGISTRATION**



Thank you for your interest in volunteering with the Baltimore County Department of Aging.

Please complete this registration page and the application page(s) for programs in which you are interested in volunteering: RSVP, Home Team, Ombudsman, Senior Centers and/or SHIP. Note: we must have your residential address, not a P.O. Box.

VOLUNTEER INFORMATION				
LAST NAME:		FIRST NAME:		MIDDLE INITIAL:
ADDRESS:			CITY:	ZIP CODE:
HOME PHONE:	OTHER PHONE:		EMAIL:	
BIRTH DATE:	GENDER: M <input type="checkbox"/> F <input type="checkbox"/>		SSN: XXX-XX-_____	
RACE: BLACK <input type="checkbox"/> NATIVE AMERICAN/ALASKAN <input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN <input type="checkbox"/> HAWAIIAN/PACIFIC ISLANDER <input type="checkbox"/> MULTIRACIAL <input type="checkbox"/>				
ETHNICITY: HISPANIC/LATINO YES <input type="checkbox"/> NO <input type="checkbox"/>				ARE YOU A VETERAN? YES <input type="checkbox"/> NO <input type="checkbox"/>
PHYSICAL LIMITATIONS:				
AVAILABILITY				
MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY/SUNDAY <input type="checkbox"/> PLEASE SPECIFY TIMES WHEN AVAILABLE:				
DEPARTMENT OF AGING VOLUNTEER PROGRAM INTEREST				
<input type="checkbox"/> FOOD AGENT (HOME TEAM) <input type="checkbox"/> LONG TERM CARE ADVOCATE (OMBUDSMAN) <input type="checkbox"/> NUTRITION SITES <input type="checkbox"/> FRIENDLY VISITING (HOME TEAM) <input type="checkbox"/> MEDICARE EDUCATION (SHIP) <input type="checkbox"/> RSVP <input type="checkbox"/> SENIOR CENTERS				
Individuals interested in volunteering with the Baltimore County Department of Aging who are aged 55 or older are automatically included as active participants in the Retired Senior Volunteer Program (RSVP).				
TRANSPORTATION				
Primary means of transportation:				
How far are you willing to travel to your assignment? 5 MILES <input type="checkbox"/> 10 MILES <input type="checkbox"/> 10+ MILES <input type="checkbox"/>				
EMERGENCY CONTACT				
NAME:				
PHONE:		RELATIONSHIP:		
AUTHORIZATION				
By signing below, you certify that all information on this registration and application is true.				
VOLUNTEER SIGNATURE:				DATE:



**RETIRED SENIOR VOLUNTEER PROGRAM OF BALTIMORE COUNTY
VOLUNTEER APPLICATION**



Use your talents to give back to your community. Local government agencies and nonprofit organizations are looking for volunteers to assist them in carrying out their organization's mission.

VOLUNTEER/WORK EXPERIENCE	
PREVIOUS OCCUPATION:	
PREVIOUS VOLUNTEER EXPERIENCE:	
INTERESTS, SKILLS, HOBBIES:	
HOW DID YOU FIND OUT ABOUT RSVP?	
PREFERRED VOLUNTEER ASSIGNMENT	
Please indicate your top three volunteer placement requests.	
1)	
2)	
3)	
CRIMINAL BACKGROUND	
Have you ever been convicted of a serious crime, including but not limited to murder, sex offense, or weapons offense? YES <input type="checkbox"/> NO <input type="checkbox"/>	
If you answered YES to the above question, please explain fully:	
Because some volunteer assignments serve vulnerable populations, some volunteers may be required to complete a background investigation. If you do not wish to be placed in a volunteer assignment that requires such measures, please select "Opt-Out": OPT-OUT <input type="checkbox"/>	
DESIGNATION OF INSURANCE BENEFICIARY	
NAME:	RELATIONSHIP:
PHONE:	ADDRESS:
AUTHORIZATION	
By signing below, you are consenting to participate in the RSVP program and affirm that you are at least age 55.	
APPLICANT SIGNATURE:	DATE



THE HOME TEAM PROGRAM VOLUNTEER APPLICATION



Through the Baltimore County Home Team, volunteers provide friendly in-home and telephone visits to eligible older adults who lack social supports and are at risk of social isolation.

VOLUNTEER OPPORTUNITY

Are you interested in providing: IN-HOME VISITS? AND/OR TELEPHONE VISITS?

EXPERIENCE

Have you ever worked with the following populations (check response below):

SENIORS? YES NO

PEOPLE WITH COGNITIVE IMPAIRMENT? YES NO

PEOPLE WITH MENTAL ILLNESS? YES NO

PEOPLE WITH DISABILITIES? YES NO

VOLUNTEER INTEREST

Why would you like to become a Home Team volunteer?

How did you hear about the Home Team Program?

Are you willing to complete a background check? (required) YES NO

JOB PLACEMENT SPECIFICATIONS

We serve a wide range of seniors. Can you fulfill the needs of a client who (check response below):

USES TOBACCO? YES NO

HAS PETS? YES NO

HAS DISABILITIES? YES NO

HAS A MENTAL ILLNESS? YES NO

HAS A COGNITIVE IMPAIRMENT? YES NO

REFERENCES

Please provide two references of persons who you have known for at least 3 years and are not related to you.

1. NAME:	RELATIONSHIP:
ADDRESS:	EMAIL:
CITY/STATE:	ZIP: PHONE:

2. NAME:	RELATIONSHIP:
ADDRESS:	EMAIL:
CITY/STATE:	ZIP: PHONE:

DISCLAIMER

Home Team clients may have compromised immune systems and we take precautions to prevent the spread of disease. If you currently have a highly contagious communicable disease, please be advised that you may place our clients at risk if you wish to be an in-home visitor. Please consider opting out of submitting your application until such a time of little to no risk of exposure, or you are welcome to apply for a volunteer position with non-direct client contact, such as a telephone visitor.

APPLICANT SIGNATURE:

DATE

**OMBUDSMAN PROGRAM
VOLUNTEER ADVOCATE APPLICATION**



Ombudsman is an advocacy program created to protect the rights and promote the well being of long term care residents.

EDUCATIONAL BACKGROUND	
Please indicate your highest completed level of education: HIGH SCHOOL <input type="checkbox"/> AA <input type="checkbox"/> BA/BS <input type="checkbox"/> MA/MS <input type="checkbox"/> PhD <input type="checkbox"/>	
EMPLOYMENT BACKGROUND	
Please indicate your current employment status: EMPLOYED <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/>	
Please list your current/most recent employer first.	
1. ORGANIZATION: POSITION/TITLE:	YEARS ____ to ____ CITY/STATE: TYPE OF WORK:
2. ORGANIZATION: POSITION/TITLE:	YEARS ____ to ____ CITY/STATE: TYPE OF WORK:
3. ORGANIZATION: POSITION/TITLE:	YEARS ____ to ____ CITY/STATE: TYPE OF WORK:
OMBUDSMAN PROGRAM INTEREST	
How did you learn about the Ombudsman Program? Why would you like to become an Ombudsman volunteer? Have you ever visited, worked, or volunteered in a nursing home/assisted living facility? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please describe previous experience with the facility.	
REFERENCES	
Please provide two references of persons who you have known for at least 3 years and are not related to you.	
1. NAME: ADDRESS: CITY/STATE:	RELATIONSHIP: EMAIL: ZIP: PHONE:
2. NAME: ADDRESS: CITY/STATE:	RELATIONSHIP: EMAIL: ZIP: PHONE:
APPLICANT SIGNATURE:	DATE



BALTIMORE COUNTY SENIOR CENTERS
VOLUNTEER APPLICATION



There are 20 senior centers throughout Baltimore County. Volunteering at a senior center allows you to share your professional or personal skills in a rewarding work environment.

VOLUNTEER POSITION

Please indicate which volunteer position you wish to apply for:

- CLASS INSTRUCTOR, specify type of class:
- DATA ENTRY
- ENTERTAINER
- EVENT PLANNER
- FITNESS CENTER MONITOR
- OFFICE/CLERICAL
- GARDENING
- GIFT SHOP ASSISTANT
- OTHER (please specify):
- GRAPHIC ARTIST
- HEALTH EDUCATOR
- LEADERSHIP/EXECUTIVE BOARD
- LUNCH PROGRAM ASSISTANT
- MARKETING
- BLOOD PRESSURE MONITOR
- RECEPTIONIST/FRONT DESK
- TRIP COORDINATOR

Please indicate any skills or experience you may have related to the volunteer position(s) to which you are applying.

VOLUNTEER PLACEMENT LOCATION

Check the senior center(s) where you would like to volunteer.

- ARBUTUS
- ATEAZE
- BYKOTA
- CATONSVILLE
- COCKEYSVILLE
- EATING TOGETHER NUTRITION SITE:
- EDGEMERE
- ESSEX
- FLEMING
- HEREFORD
- JACKSONVILLE
- LANSDOWNE
- LIBERTY
- OVERLEA
- PARKVILLE
- PIKESVILLE
- REISTERSTOWN
- ROSEDALE
- SEVEN OAKS
- VICTORY VILLA
- WOODLAWN

APPLICANT SIGNATURE:

DATE



**SHIP - STATE HEALTH INSURANCE PROGRAM &
SMP - SENIOR MEDICARE PATROL
VOLUNTEER APPLICATION**



LOCAL HELP FOR PEOPLE WITH MEDICARE

**SHIP/SMP trains volunteers to be Medicare Counselors, Part D Counselors,
Speakers for Medicare Minute, and Administrative Assistants.**

VOLUNTEER POSITION

Which of the following SHIP/ Senior Medicare Patrol (SMP) volunteer positions interest you?

- | | |
|--|---|
| <input type="checkbox"/> MEDICARE PHONE COUNSELOR | <input type="checkbox"/> MEDICARE MINUTE PUBLIC SPEAKER |
| <input type="checkbox"/> MEDICARE PART D COUNSELOR
(SERVING AT SENIOR CENTER LOCATIONS IN THE FALL) | <input type="checkbox"/> ADMINISTRATIVE ASSISTANT |

WORK HISTORY/VOLUNTEER EXPERIENCE

Please list your most recent position first. Describe how each work experience can relate to your SHIP/ SMP volunteer role.

1. ORGANIZATION:	YEARS ____ to ____	CITY/STATE:
POSITION/TITLE:	TYPE OF WORK:	
ROLE: PAID <input type="checkbox"/> VOLUNTEER <input type="checkbox"/>	DESCRIPTION:	
2. ORGANIZATION:	YEARS ____ to ____	CITY/STATE:
POSITION/TITLE:	TYPE OF WORK:	
ROLE: PAID <input type="checkbox"/> VOLUNTEER <input type="checkbox"/>	DESCRIPTION:	

SHIP/SMP PROGRAM INTEREST

Why would you like to become a SHIP/ SMP volunteer?

REFERENCES

Please provide three references, including at least one professional or work reference that is not related to you and who we may contact to ask about your qualifications.

1. NAME:	PHONE:	HOW LONG KNOWN:
RELATIONSHIP:		
2. NAME:	PHONE:	HOW LONG KNOWN:
RELATIONSHIP:		
3. NAME:	PHONE:	HOW LONG KNOWN:
RELATIONSHIP:		

CRIMINAL BACKGROUND CHECK

I hereby authorize the Baltimore County Department of Aging to perform a comprehensive background check (national criminal records check, references, and may include checks on my driving record) as required by the SHIP/SMP Program, because all of its volunteer roles are "positions of trust." If you do not wish to be placed in a volunteer assignment that requires a background check, please select "Opt-Out." Opt-Out

DRIVER'S LICENSE AND CURRENT AUTOMOBILE INSURANCE CERTIFICATION

I hereby certify that I have a valid driver's license and current automobile insurance coverage. In the event my auto insurance policy lapses, I agree to notify the SHIP/SMP Program. Current Driver's License: State: _____ Number: _____

APPLICANT SIGNATURE:

DATE