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HOSPICE

VOLUNTEER APPLICATION

Please print:

NAME _____ DATE _____

ADDRESS _____ PHONE-HOME _____

ADDRESS2 _____ PHONE-CELL _____

CITY _____ STATE _____ ZIP _____ PHONE-WORK _____

EMAIL _____ DATE OF BIRTH _____

Are you 18 years or older? ☐ Yes ☐ No
Are you legally eligible to work in the United States? ☐ Yes ☐ No
Have you ever been convicted of a crime? ☐ Yes ☐ No
If yes, give dates and offenses: _____

How did you hear about Transitions Hospice?
☐ Volunteermatch.org ☐ Newspaper Ad ☐ Transitions Website ☐ Community Event ☐ Google ☐ Church
☐ Other (describe): _____

Areas of Hospice Interest:
☐ Companionship Volunteer ☐ Vigil Volunteer ☐ Music Volunteer ☐ Pet Volunteer
☐ Bereavement Volunteer ☐ Office Volunteer ☐ Other (describe): _____

Skills and Interests:
☐ Arts & Crafts (list): _____ ☐ Singing
☐ Play Instrument (list): _____ ☐ Office Work ☐ Read
☐ Multi-lingual (list) _____ ☐ Other _____

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VOLUNTEER APPLICATION

Person to Notify in Case of Emergency:

NAME _____ RELATIONSHIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

Experience

Current employer and occupation: _____

If Student, list school and major: _____

Describe any past volunteer experience: _____

_____

_____

Do you have a physical impairment that might affect your volunteer work? ☐ Yes ☐ No

I authorize Transitions Hospice to send text messages to my cell phone to keep me informed. ☐ Yes ☐ No

Volunteer Agreement

Becoming a hospice volunteer is a commitment of time and heart. Transitions Hospice volunteers are asked to make a commitment of one year service to our patients, families and/or administrative support staff. Each year, volunteers are given the opportunity to "re-commit" to their service at Transitions Hospice. In addition to this commitment, you understand that the following will be expected of you as a hospice volunteer:

1. Adherence to hospice philosophy and company mission;
2. Attendance at continuing education and in-service programs;
3. Compliance with all Transitions Hospice policies and procedures;
4. Advance notice of resignation from this program.

All volunteer opportunities are contingent upon the following:

1. You are legally eligible to work in the United States and provide proof of valid government issued identification (driver's license/state ID/passport);
2. Verification of the information provided on your volunteer application;
3. We receive a satisfactory response to the background investigation;
4. You submit your fingerprints for registration with IL Dept. of Public Health (IDPH);
5. Proof of satisfactory tuberculosis screening and valid Health Certification (physical exam);
6. Proof of automobile insurance, as applicable;
7. Completion of hospice volunteer orientation/training.

By signing below I confirm that all information provided in this application is accurate and truthful.

SIGNATURE _____ DATE _____

State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name _____ Full Middle Name _____ Last Name _____

Mailing Address _____ City: _____ State: _____ Zip Code _____

Other Names Used _____ Telephone _____ - _____ - _____

States Where You Have Lived? _____

☐ Male ☐ Female Race _____ Height _____ Weight _____ Date of Birth _____ Social Security Number _____

(Enter a letter from below)

Hair Color _____ Eye Color _____ Place of Birth _____

Race	**A**	Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
	B	Black or African American (Not Hispanic or Latino)
	H	Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
	I	American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
	U	Of undeterminable race. Of Untold mixture.
	W	Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ☐ Yes ☐ No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ☐ No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

_____ _____

(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

_____ _____

(Signature of Parent or Guardian when applicable) (Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

***** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED*****

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BACKGROUND CHECK AUTHORIZATION

FIRST NAME | MIDDLE NAME | LAST NAME

ADDRESS | COUNTY

CITY | STATE | ZIP

DATE OF BIRTH | PLACE OF BIRTH (STATE/COUNTRY)

DRIVER'S LICENSE # | SOCIAL SECURITY #

HEIGHT | WEIGHT | EYE COLOR | HAIR COLOR

I certify the information provided in my volunteer application is true and complete. I understand this volunteer opportunity is contingent upon verification of information provided in my application, satisfactory background checks and health screenings. I further understand that false or misleading information given in my volunteer application or interview will render my application void and will be just cause for termination in the event of my volunteer employment.

I hereby authorize Transitions Hospice and its designated agents to conduct a comprehensive review of my background prior to beginning my volunteer assignment. Transitions Hospice and its designated agents shall maintain all information received from this authorization in a confidential manner.

VOLUNTEER SIGNATURE | DATE

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BUSINESS ASSOCIATE AGREEMENT
HIPAA COMPLIANCE

1 of 3 pgs

This Business Associate Addendum ("**Addendum**") amends, and is made part of, the **Underlying Agreement** by and between Transitions Hospice LLC ("**Hospice**") and the business ("**Business Associate**"). This Addendum is effective as of September 23, 2013

RECITALS

A. Hospice is a Covered Entity and subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 as amended by the Health Information Technology for Economic and Clinical Health Act Title XIII of Division A of the American Recovery and Reinvestment Act, 2009 (HITECH Act) and regulations Promulgated thereunder, as such law and regulations may be amended from time to time (Collectively, "HIPAA");

B. Hospice and Business Associate are parties to one or more agreements and/or may in the future become parties to additional agreements (collectively, the "Underlying Agreements"), pursuant to which Business Associate provides certain services ("Services") to Hospice and, in connection with such services, creates, receives, uses or discloses for or on behalf of Hospice certain individually identifiable Protected Health Information ("PHI") relating to patients of Hospice that is subject to protection under HIPAA.

C. Hospice and Business Associate wish to comply in all respects with the requirements of HIPAA, including requirements applicable to the relationship between a Covered Entity and it's Business Associates.

NOW, THEREFORE, in consideration of the mutual promises below and the exchange of information pursuant to this Addendum, Hospice and Business Associate agree as follows:

1. Definitions.

The following terms used in this Addendum shall have the same meaning as those terms in the HIPAA regulations: Breach, Business Associate, Covered Entity, Designated Record Set, Disclosure, Electronic Protected Health Information (ePHI), Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Privacy Rule, Protected Health Information (PHI), Required By Law, Security Incident, Secretary, Unsecured Protected Health Information and Use.

2. Obligations of Business Associate.

2.1 Permitted Uses and Disclosures.

Business Associate shall not use or disclose PHI other than as permitted or required for the purposes of performing the Services, as permitted under this Addendum, or as permitted or required by law. Further, Business Associate shall not use PHI in any manner that would constitute a violation of HIPAA if so used by Hospice. However, Business Associate may use or disclose PHI:

(i) for the proper management and administration of Business Associate;
(ii) to carry out the legal and ethical responsibilities of Business Associate; or
(iii) for Data Aggregation purposes for the Health Care Operations of Hospice. If the Business Associate discloses PHI to a third party, Business Associate must obtain, prior to making any such disclosure:
  (a) reasonable written assurances from such third party that such PHI will be held confidential as provided pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to such third party: and
  (b) a written agreement from such third party to immediately notify Business Associate of any breaches of confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

2.2 Prohibited Uses and Disclosures of PHI.

Notwithstanding any other provision in this Addendum, Business Associate shall comply with the following requirements:

(i) Business Associate shall not use or disclose PHI for fundraising or marketing purposes except as permitted or required for purposes of performing the Services and consistent with the requirements of 42 U S C § 17936.

2.7 Subcontractors and Agents.
Business Associate shall require each of its subcontractors or agents to whom Business Associate may provide PHI on behalf of Hospice to agree to written contractual provisions that impose at least the same obligations to protect such PHI as are imposed on Business Associate by this Addendum and in compliance with regulations.

2.8 Access to PHI.
To the extent Business Associate maintains a Designated Record Set on behalf of Hospice, Business Associate shall make PHI it maintains or is maintained by its agents or Business Associates in Designated Record Sets available to Hospice for inspection and copying within fifteen (15) days of a request by Hospice to Hospice to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.524.

2.9 Amendment of PHI.
Business Associate shall make any amendment(s) to PHI in a Designated Record Set that Hospice directs or agrees to pursuant to Title 45, Section 164 526 of the CFR at the request of Hospice or an individual in the time and manner set forth in Hospice's health information privacy policies and procedures.

2.10 Accounting of Disclosures.
Business Associate shall document all disclosures of PHI and information related to such disclosures as would be required for Hospice to respond to a request by an individual for an accounting of disclosures of PHI in accordance with Title 45, Section 164.528 of the CFR, including PHI in Electronic Health Records in accordance with HITECH. Upon request, the Business Associate agrees to provide Hospice this documentation in the time and manner set forth in Hospice's policies and procedures. To the extent a request for an accounting relates to disclosures of PHI in Electronic Health Records by Business Associate, Hospice may provide the Business Associate's contact information to the individual and the Business Associate shall provide the accounting directly to the individual.

2.11 Government Access to Records.
Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI available to Hospice and to the Secretary for purposes of determining Business Associate's compliance with HIPAA. Nothing in this Section shall be construed to require Business Associate to disclose or produce to Hospice or the Secretary communications that are subject to attorney-client privilege or that otherwise may require Business Associate to violate its ethical obligations or its professional responsibilities. Business Associate shall promptly notify Hospice in writing of any communication with the Secretary regarding PHI and shall provide Hospice with copies of any correspondence from or to the Secretary or any information the Business Associate has made available.

2.12 Required Disclosure.
If the Business Associate is confronted with legal action to disclose PHI, the Business Associate shall promptly notify Hospice to assist in obtaining a protective order or other similar order, and shall therefore disclose only the minimum amount of PHI that is required to be disclosed in order to comply with the legal action, whether or not a protective order or other order has been obtained.

2.13 Minimum Necessary.
Business Associate (and its agents or subcontractors) shall request, use and disclose only the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure.

2.14 Mitigation.
Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of PHI by the Business Associate in violation of the requirements of this Addendum.

and that such rights shall be in addition to, and not in limitation of, any other rights or remedies to which Hospice may be entitled at law or equity.

7. Hold Harmless.
Business Associate shall indemnify and hold harmless Hospice and its members, directors, officers, employees and agents, officers and directors against any and all claims, demands, losses, expenses, obligations, liabilities, actions, suits, penalties and taxes (including, without limitation, costs and reasonable attorneys' fees) of any sort that arise out of or are proximately caused by: (i) Business Associate's breach of this Addendum, including (without limitation) the failure of the Business Associate to perform its obligations with respect to PHI under this Agreement; or (ii) any use or disclosure of PHI by the Business Associate, its employees, agents, subcontractors or independent contractors that is not permitted under this Addendum. Business Associate expressly agrees that this provision obligates Business Associate to reimburse Hospice for all costs and expenses (including reasonable attorney fees) associated with any notification process that may be required under HIPAA with respect to any Breach of Unsecured PHI caused by the Business Associate, its employees, agents, subcontractors or independent contractors.

8. Interpretation.
This Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA. Any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA rules.

9. Entire Agreement of the Parties.
This Addendum supersedes any and all prior and contemporaneous Business Associate agreements or addenda between the parties and constitutes the final and entire agreement between the parties hereto with respect to the subject matter hereof. Each party to this Addendum acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, with respect to the subject matter hereof, have been made by either party, or by anyone acting on behalf of either party, which are not embodied herein. No other agreement, statement or promise, with respect to the subject matter hereof, not contained in this Addendum shall be valid or binding.

10. Regulatory References.
A reference in this Addendum to a section of regulations means the section as in effect or as amended, and for which compliance is required.

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BUSINESS ASSOCIATE AGREEMENT
HIPPA COMPLIANCE

IN WITNESS WHEREOF, each of the undersigned has caused this Addendum to be duly executed in its name and on its behalf as of the effective date.

Volunteer Name: _____

Volunteer Signature: _____ Date: _____

Transitions Hospice Representative:

Name: _____

Title: _____ Date: _____

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Media Release and Authorization

Transitions Hospice, LLC would like your permission to photograph, film or record you (the employee) for use in internal and external publications, bulletin boards, website and/or media outlets. The information will be used for the designated purposes of public relations, marketing, staff development and/or education of special programs and hospice services provided by Transitions Hospice.

☐ I hereby authorize Transitions Hospice to use any photographs and/or filming for use of internal and/or external publications, bulletin boards, and website and/or media outlets.

- I agree the photos or images collected become the property of Transitions Hospice or its representative.

☐ I do NOT authorize Transitions Hospice to use any photographs and/or filming for use of internal and/or external publications, bulletin boards, website and/or media outlets

Employee Name (print) _____

Employee Signature _____ Date _____

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Just name & Phone # - I'll call them

VOLUNTEER REFERENCE CHECK

Volunteer Name: _____

#1 Reference name/Phone number: _____

How long have you known the candidate?

How do you know the candidate?

How would you rate this person on the following?

Communication skills	Excellent	Good	Fair	Poor
Following directions	Excellent	Good	Fair	Poor
Judgment	Excellent	Good	Fair	Poor
Reliability	Excellent	Good	Fair	Poor

#2 Reference name/Phone number: _____

How long have you known the candidate?

How do you know the candidate?

How would you rate this person on the following?

Communication skills	Excellent	Good	Fair	Poor
Following directions	Excellent	Good	Fair	Poor
Judgment	Excellent	Good	Fair	Poor
Reliability	Excellent	Good	Fair	Poor

Were the results of this check satisfactory? Yes No

_____ _____

Reviewers Signature Date

(Attach reference email responses if applicable)