DELAWARE SHIP PROGRAM

Volunteer Application

Applicant's Name: _____

Date: _____ ***County:*** _____

I. Volunteer Interests and Experience

(Please note that the Delaware State Health Insurance Assistance Program (SHIP) does not accept applications from insurance agents, insurance brokers, financial planners, or employees of health care providers.)

A. AMBASSADOR volunteer position(s) of interest to you (Please check all that apply):

□ ***Marketer –*** *helps promote the SHIP program within your community*

□ ***Administrative volunteer –*** *provides administrative support including data entry and other clerical duties*

□ ***Task volunteer –*** *provides support for special short-term projects*

□ ***Educator*** *– delivers community presentations and educate Medicare beneficiaries about their options*

□ ***Screener –*** *screens clients for potential programs*

B. Why are you interested in volunteering with the Delaware SHIP?

_____

_____

_____

_____

_____

_____

_____

_____

C. Are you fluent in any language other than English (including sign language)?

□ Yes □ No If yes, please list language(s):_____

_____

D. Skills and Interests (Please check all that apply.)

□ Computer/Internet *□ Organizing/Scheduling*

□ Public speaking with large groups *□ Public speaking with small groups*

□ Public relations/Communications *□ Research*

□ Teaching/Training *□ Writing*

□ Data Entry *□ Graphic Design*

□ General Office Work

□ Assist individuals/One-on-one direct client service

□ Other _____

E. Experience (include paid and volunteer experience starting with the most recent)

Company/Organization: _____

Dates of service: From_____ to _____

Contact person: _____ Phone: _____

□ Paid employee □ Volunteer

Company/Organization: _____

Dates of service: From_____ to _____

Contact person: _____ Phone: _____

□ Paid employee □ Volunteer

F. Availability

Hours per month: □ *4 or less* □ *5 to 10* □ *More than 10*

Preferred days and times:

□ *Sunday*	□ *Morning*	□ *Afternoon*	□ *Evenings*
□ *Monday*	□ *Morning*	□ *Afternoon*	□ *Evenings*
□ *Tuesday*	□ *Morning*	□ *Afternoon*	□ *Evenings*
□ *Wednesday*	□ *Morning*	□ *Afternoon*	□ *Evenings*
□ *Thursday*	□ *Morning*	□ *Afternoon*	□ *Evenings*
□ *Friday*	□ *Morning*	□ *Afternoon*	□ *Evenings*
□ *Saturday*	□ *Morning*	□ *Afternoon*	□ *Evenings*
□ *As Needed*			

G. Are you licensed and able to drive an automobile? □ *Yes* □ *No*

II. Personal Information

A. Contact Information

Name: _____

Mailing address: _____

City: _____ *State:* _____ *Zip code:* _____

Email: _____

Home phone: _____ *Cell phone:* _____

B. Employer Information (if currently employed)

Occupation: _____

Company/Organization: _____

Mailing address: _____

City: _____ *State:* _____ *Zip code:* _____

C. Education

College/University (if any): _____

Degree/Major: _____

Dates attended: _____ Graduate? ☐ Yes ☐ No

High School: _____

Dates attended: _____ Graduate? ☐ Yes ☐ No

D. Emergency Contact

Name: _____ Relationship: _____
Home phone: _____ Other phone: _____

E. Optional

Do you have any medical conditions you would like SHIP to be aware of?
☐ Yes ☐ No
If yes, please describe: _____

_____

Do you require any special accommodations? ☐ Yes ☐ No

If yes, please describe: _____

_____

II. References

Please list two references, who are not related to you.

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

IV. Screening Questions

A. Are you affiliated with any of the following:

Insurance company, agency or broker	☐ *Yes*	☐ *No*
Financial planning service	☐ *Yes*	☐ *No*
Health insurance claims or billing service	☐ *Yes*	☐ *No*
Law firm or legal services organization	☐ *Yes*	☐ *No*
Other (please describe)	☐ *Yes*	☐ *No*

_____

B. If you answered yes to any of the above, please explain:

_____

_____

_____

_____

V. Declaration

I declare that the information provided and statements made in this application are true and complete to the best of my knowledge and belief. I also declare that I understand that the purpose of the training I receive as a SHIP volunteer is to provide services free of charge to Medicare beneficiaries and is not to be used for my personal monetary again.

Signature: _____ ***Date:*** _____

Volunteer Agreement

As a volunteer for the Delaware State Health Insurance Assistance Program (SHIP), I agree to act within the scope of my responsibilities and abide by all program policies and procedures as specified in, but not limited to the following: volunteer position descriptions, handbooks, manuals, and other guidelines. The Delaware SHIP and Delaware Department of Insurance are not responsible for any activity that I engage in or any responsibility that I assume other than those specified in the above mentioned program policies and procedures. Any action that I take outside the scope of responsibilities for my volunteer position will be taken at my own personal risk.

Nature of Volunteer Service

- I understand that as a member of the AMBASSADOR team (Marketer, Administrative volunteer, Task volunteer, Educator, and Screener); the Delaware SHIP relies upon volunteers to serve Medicare beneficiaries and their community. The scope of responsibilities varies for each team member.
- I understand that my responsibilities may include providing accurate and objective counseling and assistance with Original Medicare, Medical Assistance and Medicare Savings Programs, Medicare Advantage plans, Medicare prescription drug plans, long-term care insurance, and related health insurance coverage for Medicare beneficiaries, their representatives and caregivers, or persons soon to be eligible for Medicare.
- I understand that my responsibilities may include the use of internet-based programs to help clients identify and compare health and prescription drug plan options.
- I understand that my responsibilities may also include educating the public on Medicare, Medical Assistance, and health insurance issues that affect older Americans and people with disabilities.
- I understand that my volunteer activities may need to take place at specific counseling sites or by telephone.
- I understand that I must submit monthly documentation of my activities to the SHIP office.
- I understand that SHIP volunteers provide services free of charge to any Medicare beneficiary who seeks assistance from the program.

Confidentiality

- I understand that I will have access to certain files and other sensitive information about my clients, including medical, insurance, financial and other personal data of a sensitive or confidential nature.
- I agree to keep such information confidential and to use it only to perform my duties as a SHIP volunteer, to the extent that a client explicitly authorizes.
- Upon completion of a counseling session, I will submit directly to the SHIP office or shred personal documentation received by the client.

Non-Conflict of Interest

SHIP volunteers cannot promote private or personal interests as they go about performing the duties described in SHIP program policies and guidelines. To comply with this requirement, I agree to the following:

- I will in no way attempt to conduct market research, or solicit or persuade clients to purchase or enroll in a specific type of health insurance coverage, to switch from one carrier to another to replace existing insurance coverage, to go to a specific provider of service for treatment, or to direct a client to a specific agent/broker, or to any profit-based billing service.
- I will not disclose or use confidential or other personal information obtained from a client through my association with SHIP for personal gain or the gain of my employer or any other party.

Agreement

- I agree to serve in the role(s) of _____.
- I agree to attend initial and update training programs as required.
- I agree to respect the confidentiality of my clients and to exercise good faith and integrity in performing my duties as a SHIP volunteer.
- I understand that a breach of this agreement will result in the termination of my volunteer service and may subject me to liability for harm that I cause to a client through a breach of confidentiality or acting outside the scope of my responsibilities.

Volunteer's Signature: _____

County: _____ Date:_____

SHIP Director's Signature: _____

County: _____ Date: _____