HERITAGE
Home Health & Hospice

VOLUNTEER FILE CHECK LIST

NAME: _____ **DATE OF HIRE:** _____

SECTION 1

____ VOLUNTEER INFORMATION SHEET
____ VOLUNTEER APPLICATION
____ PRE-VOLUNTEER INTERVIEW
____ INDIVIDUAL JOB QUALIFICATIONS (RESUME)
____ REFERENCE CHECK (ATLEAST TWO)

SECTION 2

____ VOLUNTEER JOB DESCRIPTION
____ VOLUNTEER COMPENTETNCY SKILLS CHECKLIST
____ VOLUNTEERN ORIENTATION CHECKLIST
____ VOLUNTEER ACKNOWLEDGEMENT
____ STATEMENT OF EMPLOYABILITY EMR____ NAR____ CRIMINAL HISTORY____
____ CONFIDENTIALITY CONFLICT OF INTEREST AND DISCLOSURE STATEMENT
____ COMPLIANCE PLEDGE
____ MISCELLANEOUS

SECTION 3

____ COPY OF DRIVERS LICENSE
____ VERIFICATION OF EDUCATION/TRAINING/DIPLOMAS/STATEMENT OF FORMAL TRAINING FOR NONPROFESSIONALS
____ CURRENT CPR (if required)
____ CURRENT AUTOMOBILE INSURANCE

SECTION 4

____ INSERVICE RECORDS
____ PERFORMANCE EVALS 90 DAY____ ANNUAL____
____ ONSITE SUPERVISORY VISIT
____ COUNSELIING FORMS
____ COMMENDATIONS

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____ , acknowledge that a Computerized Criminal

APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB identifiers I supply. (This is not a consent form.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history, therefore the organization conducting the criminal history check is not allowed to discuss with me any criminal history record information obtained using this method. The agency may request that I have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search. Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

In order to complete the process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at www.txdps.state.tx.us */Crime Records/Review of Personal Criminal History* or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $24.95 to the fingerprinting services company.

(This copy must remain on file by your agency. Required for future DPS Audits)

Date of Birth: _____

_____
Signature of Applicant or Employee

_____
Date

_____
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES _____ NO _____ _____ initial

Purpose of CCH: _____

Empl ___ Vol/Contractor ___ _____ initial

Date Printed: _____ _____ initial

Destroyed Date: _____ _____ initial

Retain in your files

Rev. 09/2013

VOLUNTEER APPLICATION

PERSONAL INFORMATION

Date _____

Name _____ Phone #: (____) _____

Home Address: _____

Street City State Zip

Business Address: _____

Street City State Zip

Business Phone #: (____) _____ Social Security #: _____

SKILLS AND TALENTS

I have the following areas of experience or expertise to share as a hospice volunteer:

- ❑ Typing ❑ Word Processing ❑ Art Work
- ❑ Data Entry ❑ Answering Phones ❑ Filing
- ❑ Writing ❑ Calligraphy ❑ Baking
- ❑ Photography ❑ Public Speaking ❑ Child Care
- ❑ Carpentry ❑ Home Repair ❑ Education
- ❑ Lawn Care ❑ Auto Repair ❑ Sewing
- ❑ Hair Care ❑ Dental Care ❑ Pet Care
- ❑ Computer Hardware/Networks ❑ Computer Software/Training
- ❑ Business Operations: _____
- ❑ Foreign Language: _____
- ❑ Entertainment: _____
- ❑ Counseling: _____
- ❑ Healthcare: _____

❑ I would like to volunteer and work directly with patients and/or family
❑ I would like to volunteer in an administrative role such as special projects, office work, etc.

Signature: _____ Date: _____

HERITAGE
Home Health & Hospice

VOLUNTEER INFORMATION

Volunteer Name: _____ D.O.H.: _____

Address: _____

Cell Phone: _____ □ AT&T □ Verizon □ Sprint □ Other: _____

Home Phone: _____ Other Phone: _____

E-mail: _____

Start Date: _____ End Date: _____ Job Description Received and Signed: _____

□ Orientation Completed □ Initial Competency Evaluation Completed: □ Name Badge Received

Emergency Contact #1

Name: _____ Address: _____

Cell Number: _____ Home Number: _____ Other Number: _____

Emergency Contact #2

Name: _____ Address: _____

Cell Number: _____ Home Number: _____ Other Number: _____

Hospital of Choice: _____

HERITAGE
Home Health & Hospice

PRE- EMPLOYMENT INTERVIEW

DATE:_____ **CANDIDATE FOR EMPLOYEMENT:** ☐ **YES** ☐ **NO**

INTERVIEWEE:_____ **INTERVIEWER**_____

DO YOU HAVE HOSPICE EXPERIENCE: ☐ **YES** ☐ **NO**

DEFINE "HOSPICE CARE" IN YOUR OWN WORDS:_____

_____

_____

_____

DEFINE "PALLIATIVE CARE" IN YOUR OWN WORDS: _____

_____

_____

_____

DEFINE "BEREAVEMENT CARE" IN YOUR OWN WORDS: _____

_____

_____

_____

WHAT ARE SOME OF THE REWARDS YOU BELIEVE COME WITH BEING A HOSPICE EMPLOYEE? _____

_____

_____

_____

WHAT ARE SOME OF THE CHALLENGES YOU BELIEVE LAY IN FRONT OFA HOSPICE EMPLOYEE? _____

_____

_____

_____

DO YOU BELIEVE THAT YOU HAVE THE ABILITY TO IDENTIFY YOUR EMOTIONS IN A WAY THAT WILL NOT INTERFERE WITH YOUR PROFESSIONALISM? ☐ **YES** ☐ **NO**

IF "YES" PLEASE GIVE AN EXAMPLE OF A SITUATION WHERE YOU DEMONSTRATED THIS ABILITY. IF "NO" PLEASE EXPLAIN HOW YOU WOULD BE ABLE TO ADAPT TO AN EMOTIONALLY CHARGED AREA OF HEALTHCARE LIKE HOSPICE.

_____

_____

_____

_____

HERITAGE
Home Health & Hospice

PRE-EMPLOYMENT REFERENCE CHECK

NAME:_____ PHONE NUMBER:_____

RELATIONSHIP:_____ LENGTH OF TIME KNOWN:_____

COMMENTS:_____

_____

_____

_____ _____

ADMINISTRATIVE SIGNATURE DATE

NAME:_____ PHONE NUMBER:_____

RELATIONSHIP:_____ LENGTH OF TIME KNOWN:_____

COMMENTS:_____

_____

_____

_____ _____

ADMINISTRATIVE SIGNATURE DATE

NAME:_____ PHONE NUMBER:_____

RELATIONSHIP:_____ LENGTH OF TIME KNOWN:_____

COMMENTS:_____

_____

_____

_____ _____

ADMINISTRATIVE SIGNATURE DATE

Job Description / Performance Evaluation

Title: Volunteer ☐ **Volunteer Evaluation** ☐ **Volunteer Self Evaluation**

Job Summary:
Primary function is to provide assistance and support without compensation to hospice patient/family/hospice team. May attend IDT conferences as appropriate.

Job Classification: Clinical

Lines of Authority: Reports to the Volunteer Coordinator

Job Qualifications:

Education: High School Diploma, preferred

Licensure: Must have current drivers license if providing direct patient care. Professional Volunteers must meet requirements of specific licensure rules.

Skills: Must be able to read and write in English and follow written and verbal instructions in English effectively. Demonstrates interest in the welfare of ill and elderly.

Transportation: Reliable transportation. Valid and current auto liability insurance if providing direct patient care.

Criminal History: Must agree to and pass a criminal history check (for direct care volunteers).

Environmental and Working Conditions:
Patient's home - various conditions; possible exposure to blood and bodily fluids and infectious diseases; ability to work flexible schedule; ability to travel locally; some exposure to unpleasant weather. Must have Hepatitis acceptance/declination.
Office - routine office environment, Noise level may be moderately high, ability to work a flexible schedule

Physical and Mental Effort:
Prolonged standing and walking required. Occasional need to lift, pull, carry and push items. Frequent need to stoop, kneel and reach while accessing files Requires working under some stressful conditions to meet deadlines, to identify patient needs, to make quick decisions and meet patient/family needs. Requires hand-eye coordination and manual dexterity.

Essential Functions:	**Evaluation**
Direct Patient Care	
Provide direct care/companionship to patient, reporting any changes to hospice staff.	
Provide preparation of meals or assist with household chores..	
Provide a clean, safe and comfortable patient environment.	
Promote positive, supportive, respectful communication and respite to patient/family.	
Provide an environment which promotes respect for patient, privacy and property.	
Administrative Support	
Provide clerical support to office staff.	
Participate in special projects/fund raisers.	
Professional volunteer	
Provide services according to the rules and standard of practice of their respective disciplines.	

Statement of Understanding: I have read the above job description and essential functions. I understand and agree to carry out these responsibilities as assigned. I understand and acknowledge that nothing contained in this job description may be construed as limiting the employer's right to discipline or terminate my employment at any time for failure to perform satisfactorily.

Employee Signature:_____ **Date:**_____

Employer Signature:_____ **Date:**_____

(For Job Description)
Evaluation Codes: 1-Does not meet job requirements/expectations 2-Occasionally meets job requirement
3 -Normally meets job requirements 4-Meets and occasionally exceeds job requirements 5-Regularly exceeds job requirements

Volunteer Competency Checklist

VOLUNTEER'S NAME:

INSTRUCTIONS: Use the following answer key to indicate the extent of knowledge:
(1) Need instruction or supervision (2) Need review (3) Feel competent to perform without supervisor
(4) Feel competent to orient others

Procedures	Previous Experience	Verbal or Demo Competency Date / Initial	Comments
Hospice philosophy			
Hospice services			
Duties and responsibilities as assigned/ contacting supervisor			
Patient rights and responsibilities			
Process for complaints			
Patient confidentiality/HIPAA			
Role in emergency preparedness			
Reporting abuse, neglect and/or exploitation			
Family dynamics			
Common symptoms of dying			
Grief process related to dying			
Aspects of bereavement program			
Safety issues in the home			
Use of standard precautions			
Professional conduct/personal appearance			
Documentation of service and visits according to assignment			
Other:			

Volunteer Signature: _____ Date_____

Signature/Title of Evaluator:_____ Date_____

Hospice Volunteer Orientation/Training

I. Introduction to Hospice
- Hospice definition
- History of Hospice
- Hospice Philosophy/Goals/Services
- Fraud and Abuse in Hospice

II. Role of the Hospice Volunteer
- Supervision/Contact person
- Duties and Responsibilities
- Incident/Occurrence Reports
- Patient Rights/ Abuse, Neglect & exploitation
- Adverse/Inclement Weather
- Patient Confidentiality/HIPAA
- Patient/Family Complaints
- Communication Techniques
- Professional Conduct
- Personal Appearance/dress code
- Smoke Free Workplace
- Ethics
- Compliance Program

III. Safety
- Infection Control
- Workplace Violence
- Risk Management
- Personal Safety
- Fire Safety
- OSHA

IV. Death and Dying
- Self Understanding/self test
- Family Unit/Family Dynamics
- Psychological Issues Related to Death & Dying
- Common Symptoms in the Dying Patient

V. Grief and Bereavement
- Grief
  - Symptoms of Grief
  - Understanding Grief
- Bereavement

Volunteer Signature:_____**Total orientation hours**_____

Management signature:_____ **Date:**_____

VOLUNTEER ACKNOWLEDGMENT

Confidentiality: Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the clients according to 1996, Health Information Portability and Accountability Act (HIPAA). Due to the nature of our work, each volunteer will gain, directly or indirectly, sensitive and confidential information on clients/patients and staff members. The health care professional safeguards the client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient information, etc. This information should be shared only with those persons who, due to their position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If an volunteer is in doubt as to whether or not certain information may be shared, s/he should consult with his/her supervisor.

Drug Testing Policy: Agency maintains a drug free workplace policy with regard to the possession, use, distribution and sale of drugs or alcohol. All volunteers are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession or use of a controlled substance or any alcoholic beverages while in the workplace or on Company paid time. Violation of ths policy can result in disciplinary action, up to and including termination of employment. I acknowledge I have received a copy of the agency's policy on drug testing.

Harassment Policy: This agency is committed to providing a work environment, that is free from all forms of discrimination and unlawful harassment including sexual harassment. This policy applies to all volunteers including management personnel. Sexual harassment is any unwelcome sexual advances either explicit or implicit as a term or condition of employment. Improper behavior may be verbal, visual, or physical in nature and/or the creation of a hostile environment. Management will investigate complaints of sexual harassment promptly, impartially and without fear of retaliation to the volunteer. An volunteer should report the alleged incident immediately and confidentially to the appropriate manager or Human Resources.

Non Solicitation/Illegal Remuneration: Agency does not reimburse or provide incentives to physicians, durable equipment providers, family or other referral entities or patient referrals for hospice services. Volunteers may not solicit patients for the agency. Volunteers found in violation of this non-solicitation policy will be subject to discipline up to and including termination of employment.

Non-Discrimination: Agency does not discriminate against employees, clients or volunteers based on age, race, color, religion, military status, gender preference, genetic information, sex, marital status, national origin, disability, or source of payment.

Abuse, Neglect, and Exploitation: Agency volunteers will report suspected abuse, neglect and/or exploitation to the state departments of both the Texas Department of Family and Protective Services, the Department of Aging and Disability Services, and Agency management. Agency volunteers suspected of abuse, neglect, or exploitation will be suspended immediately, an investigation will be conducted, and if the investigation validates the claim, the volunteer will be terminated.

Agency Policies: I acknowledge that I have read, understand, and will comply with all applicable agency policies and guidelines.

Volunteer:_____ Date:_____

STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by the Agency and agree that the Agency may conduct a State of Texas criminal history check. I agree to a search of the Nurse Aide Registry and the Employee Misconduct Registry prior to employment and at least every 12 months if hired. I understand that these checks will determine if I have a criminal conviction or have committed certain conduct that will bar me from employment with this Agency. I understand that I am unemployable if listed as unemployable in the NAR or EMR per TAC §93.3 and TxH&SC Chapter 253; or if listed as unemployable in the Office of the Inspector General's List of Excluded Individuals and Entities (LEIE) pursuant to sections 1128 and 1156 of the Social Security Act.

Criminal History Check

I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that my employment is pending the results of the criminal history check, and that I may not have face-to-face patient contact or have access to patient records until results are returned. I will be notified of results.

CONVICTIONS BARRING EMPLOYMENT.

(A) A person for whom the facility is entitled to obtain criminal history record information may not be employed in a facility if the person has been convicted of an offense listed in this subsection:

- An offense under Chapter 19, Penal Code (criminal homicide);
- An offense under Chapter 20, Penal Code (kidnaping and unlawful restraint);
- An offense under Section 21.02, Penal Code (continuous sexual abuse of a young child or children);
- An offense under Section 21.08, Penal Code (indecent exposure);
- An offense under Section 21.11, Penal Code (indecency with a child);
- An offense under Section 21.12, Penal Code (improper relationship between educator and student);
- An offense under Section 21.15, Penal Code (improper photography or visual recording);
- An offense under Section 22.011, Penal Code (sexual assault);
- An offense under Section 22.02, Penal Code (aggravated assault);
- An offense under Section 22.021, Penal Code (aggravated sexual assault);
- An offense under Section 22.04, Penal Code (injury to a child, elderly individual, or a disabled individual);
- An offense under Section 22.041, Penal Code (abandoning or endangering a child);
- An offense under Section 22.05, Penal Code (deadly conduct);
- An offense under Section 22.07, Penal Code (terroristic threat);
- An offense under Section 22.08, Penal Code (aiding suicide);
- An offense under Section 25.031, Penal Code (agreement to abduct from custody);
- An offense under Section 25.08, Penal Code (sale or purchase of a child);
- An offense under Section 28.02, Penal Code (arson);
- An offense under Section 29.02, Penal Code (robbery);
- An offense under Section 29.03, Penal Code (aggravated robbery);
- An offense under Section 32.53 Penal Code (exploitation of a child, elderly individual, or disabled individual);
- An offense under Section 33.021, Penal Code (online solicitation of a minor);
- An offense under Section 34.02, Penal Code (money laundering);
- An offense under Section 35A.02, Penal Code (Medicaid fraud);
- An offense under Section 36.06, Penal Code (obstruction or retaliation);
- An offense under Section 42.09, Penal Code (cruelty to livestock animals);
- An offense under Section 42.092, Penal Code (cruelty to nonlivestock animals); or
- A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection.
- An offense the Agency determines to be contraindicated to employment with the consumers the Agency serves

(B) A person may also be barred from employment the duties of which involve direct contact with a client in a facility if convicted of any of the following crimes within the past 5 years:

- An offense under Section 22.01, Penal Code (assault punishable as a Class A misdemeanor or as a felony);
- An offense under Section 30.02 , Penal Code (burglary);
- An offense under Chapter 31, Penal Code (theft that is punishable as a felony);
- An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution), that is punishable as a Class A misdemeanor or a felony; or
- An offense under Section 32.46, Penal Code (securing execution of a document by deception punishable as a Class A misdemeanor or a felony) .
- An offense under Section 37.12, Penal Code (false identification as a peace officer); or
- An offense under Section 42.01 (a) (7), (8), or (9), Penal Code (disorderly conduct).

(C) In addition to the prohibitions on employment prescribed by Subsections (A) and (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:

- Of an offense under Section 30.02, Penal Code (burglary); or
- Under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.

(D) For purposes of this section, a person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Section 5(c), Article 42.12, Code of Criminal procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment. I understand that all information obtained by this agency regarding any criminal history will remain confidential.

I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

_____

Signature of Applicant Date

For Agency Use Only: Criminal History, Employee Misconduct Registry (EMR), Nurse Aide Registry (NAR), and LEIE checks completed:

❑ Criminal History Check completed on-line ❑ Other Convictions identified on Criminal History. (Document reason hiring in Comments below)

❑ NAR ❑ EMR checked online at https://emr.dads.state.tx.us/DadsEMRWeb/ ❑ LEIE

❑ Applicant employable ❑ Applicant not employable ❑ Comments: _____

_____

_____

_____

Verified By_____ Date_____

CONFIDENTIALITY/CONFLICT OF INTEREST DISCLOSURE STATEMENT

CONFIDENTIALITY/NON-DISCLOSURE OF COMPANY OR PATIENT/CLIENT INFORMATION:

The Health Information Portability and Accountability Act (HIPAA) ensures the patient/client's right to privacy of Protected Health Information to be maintained at all times. Any information related to the care of patient/clients through this Agency will be held as confidential. All information, written or verbal, will be disclosed only to appropriate health care personnel, appropriate staff, those with a "need to know basis", or to individuals the patient/client requests.

CONFLICT OF INTEREST DISCLOSURE STATEMENT:

I acknowledge I have read the policy and procedure regarding conflict of interest and the procedure for disclosure. I understand that if I have an outside relationship that is personal, professional, or otherwise, with a patient/client, vendor, or potential business associate, I must disclose the nature of that relationship to my supervisor, or Administrator as soon as the relationship is established. I also understand that I forfeit any voting privileges, decision making capacity, and input from any activities associated with said relationship.

I,_____ as an employee, or member of the Board of Directors or Interdisciplinary Committee, am providing the following disclosure as potential conflict of interest:

_____

_____

_____

_____

_____

❑ I have no conflict of interest to report

_____ _____ _____

Name (Please Print) Signature Date

Reported conflict of interest reviewed by the Board of Directors with clearance provided.

_____ _____

Signature of Board Member(s) providing clearance Date

COMPLIANCE PLEDGE

Heritage Hospice of Texarkana, LLC

(Completed On Hire and Annually)

The undersigned is a current Board of Directors member, Interdisciplinary Team (IDT) member, owner, officer, director, or person who performs billing or coding functions on behalf of the Agency or an employee of the Agency. In that capacity, the undersigned hereby affirms that:

I have received the Agency Standards of Conduct, have had an opportunity to have questions regarding the Standards of Conduct answered, and agree to conduct myself in accordance with same in all dealings with or on behalf of the Agency;

I have completed the Compliance Training and Education Program as required by the Agency Compliance Program;

I am not aware of any actual or potential unreported activity by any person or entity acting for or in conjunction with the Agency which is known or believed by me to be in violation of any applicable federal or state law, rule or regulation;

I understand the importance of compliance with applicable laws, rules and regulations to the Agency and to the government and third-party payers;

I understand that all Agency representatives are expected to report any suspected violations of these laws, regulations, or rules to their supervisor or the Compliance Officer. I understand that I must also report any suspected violations of the policies or the standards and procedures of the program, and that I may anonymously report any suspected violations through the Compliance Dropbox or the Hotline # _____. I understand that conduct in accordance with the Agency Compliance Program will be a condition of my continued relationship with the Agency. I understand that failure to comply with the program may subject me to sanctions or discipline, including but not limited to termination of employment, and/or privileges; and

I am not currently and have not been subject to any criminal charge or conviction involving any government business nor any conviction, exclusion action, disciplinary action, debarment or proposed debarment, or loss or limitation of licensure, privilege or employment as a result of any alleged violation of applicable state or federal law, rule or regulation.

Signed this _____ day of _____, 20____.

_____

Signature

_____

Printed Name

_____

Title or Job Description