VOLUNTEER PROGRAM

Patient Care Volunteers
Patient Care Volunteers offer emotional support, companionship, respite, and friendly visits to patients in their homes or nursing facilities. They spend time with patients sharing music, reading, and recording life stories. Patients and their families appreciate the caring attention and support of these volunteers.

Office and Administrative Support
Volunteers also support the work of Wren Hospice by providing important clerical and administrative assistance in the office.

VOLUNTEER REQUIREMENTS

Time Commitment: Volunteers are asked to commit to providing a minimum of two hours of service per month but any time a volunteer is available is appreciated.

Application and paperwork: Wren Hospice volunteers are required to complete a volunteer application and all other necessary paperwork.

Training: All prospective volunteers must participate in our free training program. Volunteers are required to complete the entire training that covers the physical, emotional, psychosocial and spiritual aspects of end of life care. Bereavement volunteers participate in the initial training and one additional training session specifically tailored to their role.

Background Check/Drug Test: A state criminal background check (known as a SLED Check) is necessary for volunteers prior to beginning work with Wren Hospice. All direct patient care volunteers may be required to submit to a drug test prior to volunteering.

Tuberculosis (TB) Check: All prospective volunteers must have a free, 2-step tuberculosis testing screen done by Wren Hospice or have documentation of TB test in the prior 12 months. Volunteers must be clear of tuberculosis to be a Hospice Volunteer.

Reference Letters: All prospective volunteers must have Wren Hospice reference forms completed and returned by two references.

Volunteer Application

Name: ______________________________________ Phone: (H) _____________________

Address: ____________________________________ (C) _____________________

____________________________________ (W) _____________________

Email: ____________________________________ DOB: _____________________

Emergency Contact: ______________________________ Relation: __________________

Phone: ____________________________ Alt. Phone: ________________________

Previous Volunteer Experience: ____ No ____ Yes Dates: ___________

Where and describe activities:____

____

Reason for volunteering: ____

____

Volunteer Preference:

___ Direct Patient Care/Visits ____ Administrative ____ Special Projects ____ Professional

Type of Profession: _____________________________ Available Services: _________________

I am interested in the following areas of volunteering: (check all that apply)

___Companionship/Visiting

___Transportation Assistance

___Light House Work Duties

___Letter/Journal Writing

___Delivering Baked Goods

___Foreign Language Translator

___Light Cooking/Meal Preparations

___Providing Respite for Caregiver (Sitting with Patient)

___Grocery Shopping

___Reading

___Special Projects: (i.e. ramp building, maintenance)

___Administrative/Clerical Duties

___ Baking Cookies/Cakes

___Craft/Making Cards

Days and times you can volunteer? (check all that apply)

__ Monday __ Tuesday __Wednesday __Thursday __Friday ___Saturday __ Sundays

__Early Mornings __Mid-Mornings __Early Afternoons __ Late Afternoons __ Evenings

Available to volunteer? ___1 x week ___1 x month ____ 2 x month ____ Other

Do you possess any certifications, licenses, special trainings? If so, explain:

____

Describe your strengths: ____

____

____

Special skills or talents: ____

____

HAVE YOU EVER BEEN CONVICTED AND/OR BEEN FOUND BY A COURT OF COMPETENT JURISDICTION OR A STATE AGENCY OF ABUSING, NEGLECTING OR MISTREATING PATIENTS OR OF MISAPPROPRIATING PATIENTS PROPERTY IN THIS STATE OR IN ANY OTHER STATE? ____ YES ____ NO

HAVE YOU EVER BEEN CONVICTED OF (1) FELONY, (2) CRUELTY TO PERSONS, OR (3) ASSAULT OF A VICTIM SIXTY YEARS OF AGE OR OLDER? ____ YES ____ NO

HAVE YOU EVER BEEN SANCTIONED BY A HEALTHCARE LICENSING AGENCY IN THIS OR ANOTHER STATE OR IN ANY OTHER UNITED STATES OR FOREIGN JURISDICTION? ____ YES ____ NO

PLEASE EXPLAIN AND IDENTIFY THE NATURE AND THE DATE OF THE OFFENSE, AND THE UNDERLYING CIRCUMSTANCES OR OTHER INFORMATION TO HELP US EVALUATE YOUR CURRENT FITNESS TO BECOME A VOLUNTEER.

____

____

____

By signing below, I certify that all of the above information is true to the best of my knowledge. My signature also certifies that I give Wren Hospice permission to the following:

- To contact the above listed references on my behalf
- To obtain a SLED check
- To obtain a copy of any professional certifications/licensures if applicable
- To obtain a medical release from my physician stating my current health status if needed

Applicant Signature: ____________________________________ Date: ____________

Wren Hospice Volunteer Reference #1
Request Authorization

Volunteer Applicant Name: ____

I hereby authorize permission and request that you release information, answer questions and/or make comments concerning me as requested below.

Volunteer Applicant Signature: _______________________________________ Date: __________

Reference Name: ____

Address: ____

____

Email: ___________________________________ Phone: ________________

Your name has been given as a reference by the volunteer applicant above who has applied for volunteer work With Wren Hospice. A prompt reply to this form will be appreciated and will help us complete our files and make volunteer assignments. Your reply will be held in strict confidence. A return envelope is enclosed for your convenience or scan and email to tim@wrenhospice.com, fax (864) 326-3433.

Thank you for your assistance.

Please rank the applicant based on the following areas:

Responsible	Poor	Fair	Good	Very	Good	Excellent
Punctuality	Poor	Fair	Good	Very	Good	Excellent
Dependability	Poor	Fair	Good	Very	Good	Excellent
Willingness to assume responsibility	Poor	Fair	Good	Very	Good	Excellent
Ability to follow instructions	Poor	Fair	Good	Very	Good	Excellent
Work Ethic	Poor	Fair	Good	Very	Good	Excellent
Compassionate	Poor	Fair	Good	Very	Good	Excellent
Critical Thinking	Poor	Fair	Good	Very	Good	Excellent

How long have you known the applicant? _______________ Type: ☐ Personal ☐ Professional

To your knowledge, is the applicant in good physical and emotional health? ________________

Comments:

____

____

Signature: ____ Date_______________

Wren Hospice Volunteer Reference # 2 Request Authorization

Volunteer Applicant Name: ____

I hereby authorize permission and request that you release information, answer questions and/or make comments concerning me as requested below.

Volunteer Applicant Signature: ____ Date: ___________

Reference Name: ____

Address: ____

____

Email: ______________________________________ Phone: _________________

Your name has been given as a reference by the volunteer applicant above who has applied for volunteer work With Wren Hospice. A prompt reply to this form will be appreciated and will help us complete our files and make volunteer assignments. Your reply will be held in strict confidence. A return envelope is enclosed for your convenience or scan and email to tim@wrenhospice.com, fax (864) 326-3433.

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Compassionate	Poor	Fair	Good	Very	Good	Excellent
Critical Thinking	Poor	Fair	Good	Very	Good	Excellent

How long have you known the applicant? ________________ Type: ☐ Personal ☐ Professional

To your knowledge, is the applicant in good physical and emotional health? _________________

Comments:

____

____

Signature: ____ Date________________

Authorization for Criminal Background Check

A state criminal background check (known as a SLED Check) is necessary for Hospice Volunteers/Employees prior to beginning work with Wren Hospice.

Verification of residency for the previous twelve (12) month period must be provided by submitting a copy of **ONE** of the following:

1. A valid driver's license or identification card issued by the State of South Carolina
2. Rent, mortgage or utility receipts in the applicant's name for a home in South Carolina
3. Pay stubs in the applicant's name from a business located in South Carolina

If Wren Hospice is unable to verify an applicant has been a resident of the State of South Carolina for the preceding twelve (12) months, then a federal criminal background check will be conducted.

The following information is necessary for conducting a background check:

Name: ____

AKA and/or Maiden Name____________________________________

Address: ____

____

Date of Birth___________________ SSN# (optional) _______________________

Driver's License/State Issue ID# _______________________ State of Issue ________

Applicant's Statement and Authorization:

I, ____, do NOT have a prior conviction nor have I pled "No Contest" for child or adult abuse, neglect or mistreatment and I authorize Wren Hospice to conduct a background check on me.

Signature ____ Date:_____________

PARENT/GUARDIAN CONSENT

This consent form is provided to the parents/guardians of teen volunteers under the age of 18. As the parent/guardian you play an important role in your child's experience as a hospice volunteer, this form is intended to inform you of policies and procedures. We ask that you read this with your child and sign the statements below indicating acceptance and understanding.

- Precautions to prevent infection, as required by OSHA, are taught to your child during volunteer training.
- All patient information as required by federal privacy laws is to be kept confidential. Your child will sign a Statement of Confidentiality and understand the Health Insurance Portability Accountability Act.
- A state criminal background check is necessary prior to volunteers beginning work.
- All volunteers are required to receive a baseline TB screening, using the 2-step TST or 1-step with documentation of prior TB test in the prior 12 months.

Patient Visit Volunteers:

- Your child will be required to complete and return a Volunteer Time Record form after patient/family visits. This documentation becomes part of the medical records and is considered a confidential document. Hospice relies on this documentation for the patient's plan of care and to comply with government regulations.

I, ___________________________________, as parent/guardian of _______________________________ do hereby consent for my son/daughter to participate as a Wren Hospice Junior Volunteer as set forth in the program description.

Junior Volunteer Agreement:

I,______________________________________, will honor my commitment regarding time and service. I agree to abide by the Junior Volunteer Program Policies. I will maintain a professional attitude and appearance and will maintain high work standards in my interactions with patients, staff, and other volunteers.

Junior Volunteer Signature: ____Date: ____________

Parent/Guardian Signature: ____Date: ____________

All VOLUNTEERS UNDER AGE 18 MUST COMPLETE THIS FORM
PRINT FORM, SIGN AND BRING TO VOLUNTEER TRAINING