Halcyon
HOSPICE
& Palliative Care

Application for Volunteer Services

Name: _____ **Date:** _____

Address: _____ **City/State/Zip:** _____

Cell #: _____ **Home #:** _____ **Email:** _____

Preferred Method of Contact: ___ **Cell Phone** ____ **Home Phone** ___ **Email**

Emergency Contact: _____ **Relationship:** _____

Phone: _____

Work/Volunteer Experience: Please include medical, hospital, counseling, or related experience, if applicable.

_____

_____

Have you, in the last 7 years, been convicted of a felony (excluding any sealed or expunged convictions? YES NO

If yes, please explain: _____

_____

Why would you like to volunteer for hospice?

_____

_____

Have you suffered the loss of a close relative or friend in the past year? _____

If yes, please explain: _____

_____

How did you hear about the volunteer program?_____

Volunteer position preference: (please circle your interests)

Respite Home Visit	**Companion Facility Visit**	**11th Hour Vigil (Home/Facility) Visit**
Aromatherapy	**Massage/Reiki (must be certified)**	**Music Therapy**
Pet Therapy (animal must be certified)	**Administrative Assistance**	**Bereavement Support**
Activity Assistant/Facility	**"My Story" Historian**	**Home Assistant (meal prep, cleaning, projects)**

Time Availability

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

References

Name/Phone/Email: _____

Name/Phone/Email: _____

Name/Phone/Email: _____

Your signature indicates your approval for us to check references. The volunteer service department is not obligated to provide placement, nor are you obligated to accept the position offered.

Equal Opportunity: The hospice is committed to providing equal opportunity to all applicants so that no person shall incur discrimination because of race, color, national origin, ancestry, marital status, sex, sexual orientation, religion, age, disability, or veteran status; and that transactions or decisions will be based on position requirements and/or business reasons.

Signature: _____ Date: _____

Interviewer: _____ Date: _____

Notes:

THE PURPOSE OF THIS FORM IS TO NOTIFY YOU THAT A CONSUMER REPORT WILL BE RUN ON YOU IN THE COURSE OF CONSIDERATION FOR VOLUNTEERING WITH:

HALCYON ENTERPRISES, INC.

This includes all subsidiary companies of Halcyon Enterprises, Inc.

Please use your <u>full name</u> and Please Print

Last Name_____ First Name_____ Middle_____

Social Security #_____ Date of Birth_____ Age_____

Driver's License #_____ State of Issue_____

Present Address_____

If new resident please list prior address:

Address_____

City_____ State_____ Zip_____

County_____

Please list any other name(s) you may have worked under_____

_____

In connection with this request, I authorize all corporations, former employers, credit agencies, educational institutions, law enforcement agencies, city, state, county and federal courts, military services and persons to release information they may have about me to the person or company with which this form has been filed, or their agent, Background Information Services, Inc. This releases the aforesaid parties from any liability and responsibility for collecting the above information.

I authorize the procurement of my Colorado worker's compensations files or any other states worker's compensation files. I also authorize a consumer credit report to be run. I understand that these files may contain negative information about my background, mode of living, character, and personal reputation. This authorization, in original or copy form, shall be valid for this and any future reports or updates that may be requested.

_____ _____

Applicant's Signature Date

Halcyon
HOSPICE
& Palliative Care

HALCYON HOSPICE VOLUNTEER AGREEMENT

I, _____, agree to serve as a volunteer with Halcyon Hospice for a period of at least six (6) months when assigned to a patient. While volunteering, my responsibilities will also include:

1. Confirming my patient visits with the volunteer coordinator, prior to the visit.
2. Document each patient visit and fax or email in the report to the volunteer coordinator within 3 days of the visit.
3. Reporting and concerns about the patient immediately to the volunteer coordinator or a hospice team member.
4. To wear my hospice name tag when visiting patients.
5. To respect and abide by all HIPPA regulations as described in the volunteer manual.

I understand that any patient/family information to which I have access either through the patient/family record or through attendance at IDT meetings is privileged and shall be held by me in strict confidence. Patient/family information will only be shared with appropriate hospice personnel.

I also understand that the following are grounds for immediate dismissal from the volunteer program:

- Attempting to convert the patient and/or family members, or promote any personal beliefs such as religious, political, or medical beliefs.
- Missing patient appointments without prior notification to the volunteer coordinator, patient or family.
- Stealing from the patient/family or the hospice.
- Any sort of abusive behavior, whether verbal or physical.

In return for my volunteer time and efforts, I will receive on going support from the staff at the hospice. In particular, I will receive training, supervision, encouragement, evaluation, and recognition from any/all Halcyon Hospice staff member.

_____
Volunteer Date

_____
Halcyon Hospice Volunteer Coordinator Date

HALCYON HOSPICE AND PALLIATIVE CARE

STATEMENT OF RIGHTS AND CONFIDENTIALITY

As an employee, volunteer, contract provider, student or intern of the Hospice, I have read the written description of legal rights that each patient is entitled to at the Hospice and as a citizen or resident of the United States. I understand that it is my responsibility to uphold and protect these rights.

As a student, I further understand that, any research or study information obtained through review or patient files will be kept strictly confidential. No identifying information about specific patients will be discussed, or written in any reports outside of the Hospice.

I understand that all general inquires and media inquires must be referred and handled through the Hospice.

I understand that any patient information, to which I have access, either through access to the medical records or through any other means, must remain confidential. I understand that in order to coordinate services for patients and families, this information is shared among, and limited to, those who have a need to know the information to perform their jobs. If I am no longer involved with the Hospice, I am still responsible for safeguarding any patient and family protected heath information obtained through my work. I further understand that maintaining confidentiality regarding patients, families, employees, volunteers and business matters is of the highest ethical importance and is regulated by State and Federal laws.

I understand that this statement will become a permanent part of my personnel file, volunteer file, or student file, or record. I understand it is my responsibility to ask my immediate supervisor for an explanation of any statement I do not understand.

Signed: _____ Date: _____

Printed Name: _____

2/07
Rev:

Conflicts of Interest policy

I. INTRODUCTION

The Hospice encourages and supports outside interactions of its members and employees with federal, state, local and business and industry entities. Since outside interactions also carry with them an increased potential for conflicts of interest and/or commitment, either actual or perceived, it is important to understand the following:

(a) many conflicts that are properly disclosed can be adequately managed without detriment to the reputation, integrity or position of the hospice and the individual;
(b) in most cases, problems associated with actual or perceived conflicts of interest or commitment do not arise from the conflicts *per se*, but rather are the result of a failure to openly acknowledge and actively manage them;
(c) it is important to outline the hospice process for identifying, assessing and managing these potential conflicts to assure that both the integrity of the Hospice and the core activities of its administrators and governing members, staff and volunteers are protected;
(d) there is a need to provide flexibility for individual disciplines to establish procedures in identifying and managing of potential conflicts of interest and commitment that are consistent with the intentions of this policy; and
(e) it is critical to establish guidelines, in accordance with requirements from federal for those relationships with outside organizations that will help to assure the primacy of integrity and delineate the bounds of acceptable conduct.

This administrative policy statement is designed to outline the Hospice's approach to identifying and evaluating potential conflicts of interest and commitment issues for all employees, contractors and the hospice; to assist in carrying out the shared responsibility of addressing conflict of interest and commitment issues. This administrative policy also provides hospice guidelines for the disciplines of the Hospice to follow in developing more detailed procedures that minimize potential conflict situations. The policy applies to all employees, contractors and administrators and governing members, professional staff members, as well as consultants.

II. DEFINITIONS

A. Conflicts of Commitment

The term "conflict of commitment" refers to situations in which outside relationships or activities (such as professional consulting for a fee) adversely affects, or has the appearance of adversely affecting, a commitment to his/her Hospice duties or responsibilities, as it were, with the hospice, whether as a board member, consultant, employee, volunteer or vendor. All such information is considered proprietary and the "engaged" party will maintain this duty of confidence.

B. Conflicts of Interest

The term "conflict of interest" refers to situations in which financial or other personal considerations may adversely affect, or have the appearance of adversely affecting professional judgment in exercising any Hospice duty or responsibility in administration, management and other professional activities. The bias such conflicts could conceivably impart may inappropriately affect the goals of the Hospice or administrative programs. The education of volunteers, the methods of interpreting data, the hiring of staff, procurement of materials, and other administrative tasks at the Hospice must be free of the undue influence of outside interests. This conflicts policy also precludes anyone who has performed professional

The education of volunteers, the methods of interpreting data, the hiring of staff, procurement of materials, and other administrative tasks at the Hospice must be free of the undue influence of outside interests. This conflicts policy also precludes anyone who has performed professional duties on behalf of the hospice from sharing information that is considered proprietary with any outside entity, during or after the relationship The mere appearance of a conflict may be as serious and potentially damaging as an actual distortion of administrative goals, processes, or outcomes. Reports of conflicts based on appearances can undermine public trust in ways that may not be adequately restored even when the mitigating facts of a situation are brought to light. Apparent conflicts, therefore, should be disclosed and evaluated with the same vigor as actual conflicts.

III. DISCLOSURE, REVIEW AND MANAGEMENT

Guidelines on conflicts of interest and commitment recommend that hospices should have adequate procedures for identifying potential conflicts through regular disclosure, and ensure rigorous and consistent review of such disclosures. A disclosure in and of itself is not suggestive of any impropriety; rather, it is customary and usual and benefits both the individual and the Hospice. Indeed, full disclosure of *relevant* information and the establishment of a public record are in the best interest of both the Hospice and its administrators and governing members and employees. Disclosure should not unnecessarily restrict or preclude any employee's activities. In fact, activities that may at first appear questionable may be deemed acceptable and permissible when all facts regarding the activity are examined.

The disclosure process may take different forms, but must be in writing and kept on record. At a minimum, conflict management plans must ensure adequate intra-Hospice coordination among the various members involved, including where appropriate, discussion in the governing body meetings.

At a minimum, the procedures should include:
1. Requisite disclosures by employees that contain sufficient information to satisfy the requirements for absolution. The governing body has ultimate discretion.
2. Notes from the review process. Notes on determination of conflict or not. And a central inventory with meeting minutes or in hr files.
3. Which should include a description of resolution.
4. Appeals of a decision regarding a conflict. Their requisite notes and determination.
7. A training module will be this document, to be used as needed that will go over its provisions with prospective members, volunteers or employees.

IV. PROCEDURES (Responsibility)

Responsibility for development of additional processes, if needed, to implement this policy rests with the President of the governing body and the hospice administrator.

_____	_____	_____
Signature	Date	Title and/or role

HALCYON HOSPICE AND PALLIATIVE CARE

RELEASE

I hereby agree to allow the Hospice to use my name and likeness for the purpose of promoting the Hospice and its work.

I understand this agreement may include the use of my name, voice and image by mechanical reproduction including photographs, videotapes and motion pictures. I understand that the material may be used in the public media and appear in newspapers, radio, television, etc.

I make this agreement voluntarily and understand there is no compensation involved. I also understand that this agreement has no time limit and will cover any mechanical reproduction during my stay at the hospice.

I hereby release the Hospice from any and all claims for libel, slander, invasion of privacy or any other claim based upon use of the above-described reproductions.

Yes _____

No _____

_____
Your Name

_____
Signature of Participant

_____
Date

Halcyon
HOSPICE
Patient Centered Care

Halcyon Hospice Cease & Desist

This notice is to inform you as the volunteer that terminating the volunteer/organization relationship from either party requires that all communication be terminated. This communication includes any type of contact via internet, phone, email or fax and must cease and desist on the day and time the relationship has been terminated. Contact with any patient, patient's family, care facilities or any and all information pertaining to Halcyon Hospice business is defined as communication and is included and shall be terminated immediately. Any and all disregard with failure to adhere to this information may result in further actions as Halcyon Hospice deems appropriate. Your signature listed below acknowledges that you and Halcyon Hospice understand this agreement and its terms as stated in the above paragraph. In addition, by signing below, your signature shows that this information has been reviewed and explained as well as any questions regarding the Halcyon Hospice Cease & Desist answered for you.

Volunteer Signature:

_____ Date:_____

Volunteer Coordinator Signature:

_____ Date:_____

Halcyon Hospice and Palliative Care
TB (PPD) Testing and Results

Name:_____ Date of Birth:_____

Please answer a few questions before taking your PPD TB skin test. The purpose of these questions is to prevent adverse reactions to the test.

YES	NO	
____	____	Have you ever had a POSITIVE TB skin test?
____	____	Have you ever been told not to take a TB test because you are allergic to the products it Is made of?
____	____	Do you have any illness, or are taking any systemic steroids or other medication now, or in the last month which causes you to be susceptible to infection?

Signature:_____Date:_____

Reason for test: (Please circle one) New Employee Annual Exposure

#1 Date Given:	Administered by:
Drug: TB PPD (Mantoux)	
Site:	#1 Read Date:
Manufacturer:	Results:
Lot:	Read by Signature:
Exp. Date:	

#2 Date Given:	Administered by:
Drug: TB PPD (Mantoux)	
Site:	#2 Read Date:
Manufacturer:	Results:
Lot:	Read by Signature:
Exp. Date:	

Induration: quality of being hard, the process of hardening, an abnormal hard spot.

Results: Redness may be present with any result and is NOT measured.
Negative: No reaction and induration less then 5mm in diameter
Doubtful: Induration 5-9 mm in diameter
Positive: Induration measuring 10 mm or more in diameter

TB Skin Test MUST be read by a NURSE within 48-72 hours after getting skin test.
Please remember if this form is not returned, you have not completed your TB screening. Return this form to Human Resources or fax to (303) 328-2304.

HOSPICE

Hepatitis B Options

Sign only ONE:

A.

HEPATITIS B VACCINE

RELEASE OF LIABILITY

I _____ release the Hospice from any and all liability from injury or illness as a result of my receiving the Hepatitis B vaccine. To my knowledge I do not have allergies to any of the ingredients in the vaccine. Having read the Hepatitis B information sheet and having had the opportunity to ask questions, I am fully aware of all potential risks and side effects associated with receiving this vaccine.

_____/____/____/____

signature department/position date

B.

HEPATITIS B VACCINE

DECLINATION - NO VACCINE

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____/_____/_____/_____

signature department/position date

C.

HEPATITIS B VACCINE

DECLINATION - PRIOR VACCINATION

I decline the hepatitis B vaccination at this time as I have previously received the vaccination.

_____/____/____/____

signature department/position date