Office of the State Long-Term Care
OMBUDSMAN
Established within the Iowa Department on Aging

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Certified Volunteer Long Term Care Ombudsman (VOP) Application

Name: _____

Address: _____

City, Zip Code: _____

Preferred phone number: _____ ☐ Home ☐ Work ☐ Cell

Secondary phone number: _____ ☐ Home ☐ Work ☐ Cell

E-mail: _____

Best time available to contact you? _____

Are you at least 18 years of age? ☐ Yes ☐ No

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Other

Employer and/or school within last five years:

How did you learn about the Volunteer Ombudsman opportunity?

Why do you want to be a Volunteer Ombudsman?

List/describe your past and present volunteer experiences.

Describe any skills or strengths you have that would be valuable to the VOP.

Describe your computer skills:

Do you speak any languages other than English? ☐ Yes ☐ No If yes, what is your level of fluency?

Will you be able to spend a minimum of three hours every month visiting an assigned facility?
☐ Yes ☐ No

Will you be able to complete 12 hours of certification training? ☐ Yes ☐ No

Will you be able to commit to at least one year of volunteer service? ☐ Yes ☐ No

If no, are you a college student or seasonal traveler who spends several months in another state during the year? ☐ Yes ☐ No

Would you be able to commit to at least nine months of volunteer service to the Volunteer Ombudsman Program? ☐ Yes ☐ No

To maintain certification, volunteers must complete up to 10 hours of continuing education (provided by the OSLTCO) each year. Are you willing to complete this requirement to maintain certification? ☐ Yes ☐ No

Will you be able to provide your own transportation? ☐ Yes ☐ No

All Volunteer Ombudsmen will need to pass a comprehensive criminal background check before their service begins. Are you willing to consent to a criminal history records check? ☐ Yes ☐ No

Name and town of the facility where you would like to serve as a Certified Volunteer Long-Term Care Ombudsman (if known)?

Conflict of Interest

Please note when answering the questions below:

Immediate family means a member of the household or a relative with whom there is a close personal or significant financial relationship.

Long-term care facility includes nursing facility, residential care facility, elder group home and assisted living.

Managed care organization includes Iowa Total Care and Amerigroup Iowa, Inc.

Do **you** or any of **your immediate family members** currently work, or have previously worked, for a managed care organization, long term care facility, assisted living program, or elder group home or participated in the management, ownership, or operation of that entity within the previous year? ☐ Yes ☐ No

If yes, please provide the name of the entity, the position held, and the duties associated with this role.

Have **you** or any of **your immediate family members** owned, operated, or had any investment interest in any existing or proposed a managed care organization, long term care facility, assisted living program or elder group home in the past two years? ☐ Yes ☐ No

If yes, please explain:

Have **you** or any of **your immediate family members** been involved in the licensing or certification of a managed care organization, long term care facility, assisted living program or elder group home in the previous year? ☐ Yes ☐ No

If yes, please explain.

Have **you** or any of **your immediate family members** received, or have the right to receive remuneration (in cash or in kind) under a compensation agreement with an owner or operator of a long-term care facility or managed care organization within the previous two years? ☐ Yes ☐ No

If yes, please explain.

Have **you** or any of **your immediate family members** received any form of payment, gifts, or gratuity of significant value from a managed care organization long-term care facility, owner, operator, resident, or resident representative in the past two years? ☐ Yes ☐ No

If yes, please explain.

Have **you** accepted money or any other consideration from anyone other than an entity approved by the SLTCO for the performance of the Office of the State Long-Term Care Ombudsman program duties within the previous two years? ☐ Yes ☐ No

If yes, please explain.

Have **you** provided a service with an outside employer that may conflict with the duties of a Representative of this Office within the previous one year? ☐ Yes ☐ No

If yes, please explain.

In the past two years, have **you** or any of **your immediate family members** provided services to residents of a managed care organization, long-term care facility, or tenants of an assisted living or elder group home in which a member of your immediate family resides? ☐ Yes ☐ No

If yes, please explain.

Have **you** or any of **your immediate family members** served as a guardian or other surrogate decision-maker for a resident/tenant residing in a facility within the previous one year? ☐ Yes ☐ No

If yes, please explain.

In the past two years, have **you** or any of **your immediate family members** resided in a long-term care facility, assisted living or elder group home? ☐ Yes ☐ No

If yes, please provide the name and location of the entity.

Have **you** or any of **your immediate family members or friends** participated in activities which negatively affect the ability to serve residents/tenants/Medicaid members or which are likely to create a perception that the primary interest is other than as an advocate of the resident/tenant/Medicaid member within the previous one year? ☐ Yes ☐ No

If yes, please explain.

Do **you** have part-time employment that would create the perception that you could not advocate for residents, tenants or Medicaid members? ☐ Yes ☐ No

If yes, please explain.

Have **you** had a founded child or dependent adult abuse report or criminal conviction against you?

☐ Yes ☐ No

If yes, please explain.

Please note: If you have marked yes to any of the above questions, you may be asked to complete more documentation.

In the event that you become a certified volunteer ombudsman we will need to know who we should notify in case of an emergency.

_____

Name Relationship

_____

Phone Email address (if available)

IMPORTANT—PLEASE READ

If I am accepted as a Certified Volunteer Long Term Care Ombudsman, I agree to read the volunteer training manual and participate in orientation prior to beginning my volunteer duties.

I agree to volunteer no less than three hours per month advocating for residents in my assigned facility. I agree to submit reports in a timely fashion and be responsive to communication from program staff.

I understand that in order to maintain certification I must complete the required hours of continuing education in the first year of assignment and each year thereafter.

I understand that failure to fulfill these responsibilities may result in termination of volunteer duties.

VOLUNTEER PROGRAM

I understand that I am applying to be a Certified Volunteer Long Term Care Ombudsman for the Iowa Department on Aging, Office of the State Long Term Care Ombudsman.

My volunteer work will be conducted in a long term care facility, but I understand that I am NOT a volunteer for the facility.

I understand that I can contact the Office of the State Long-Term Care Ombudsman at any time for information or assistance and that contacts and referral procedures will be spelled out in my training.

By signing this application, I verify that all information is true and correct; I understand the responsibilities associated with this volunteer position and agree to abide by these terms.

Signature _____ Date _____
(or full legal name if signing electronically)

Mail completed application to:
Office of the State Long-Term Care Ombudsman
Iowa Dept. on Aging, Jessie M Parker Bldg., 510 E 12TH St, Rm 2, Des Moines, IA 50319