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

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

E-mail: _____

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

Occupation/Former Occupation:

_____

_____

How did you learn about the Volunteer Ombudsman opportunity?

_____

_____

Why do you want to be a Volunteer Ombudsman?

_____

_____

Describe your past and present volunteer experiences.

_____

_____

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

_____

_____

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

_____

_____

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

Will you be able to attend a mandatory eight hour training session? ☐ Yes ☐ No

Will you be able to commit to 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

Will you commit to attending periodic in-service and continuing education sessions provided by the Office of the State Long Term Care Ombudsman? (Not to exceed 10 hours in the first year and 6 hours each year thereafter) ☐ Yes ☐ No

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

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

_____

_____

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

Conflict of Interest

Please note when answering the questions below:

Immediate family includes father, mother, son, daughter, brother, sister, aunt, uncle, first cousin, nephew, niece, wife, husband, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepparent, stepbrother, stepsister, stepchild, half-sister, half-brother, grandparent, or grandchild.

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

Do **you** or any of **your immediate family members** currently work, or have previously worked, for a long term care facility or participated in the management, ownership, or operation of a long-term care facility within the previous year? ☐ Yes ☐ No
If yes, please provide the name of the facility, the position held, and the duties associated with this role.

_____

_____

Have **you** or any of **your immediate family members** owned or had a financial interest in any existing or proposed long term care facility or service 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 long term care facility or the provision of a long-term care service in the past 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 from a long-term care facility, owner, operator, resident, or resident representative in the past two years?

☐ Yes ☐ No

If yes, please explain.

_____

_____

In the past two years, have **you** or any of **your immediate family members** provided services such as (including but not limited to financial, insurance, legal, business, ministry, etc.) to residents of a long-term care facility in which a member of your immediate family resides? ☐ Yes ☐ No

If yes, please explain.

_____

_____

In the past two years, have **you** or any of **your immediate family members** participated in activities which negatively affect the ability to serve residents or which are likely to create a perception that the primary interest is other than as an advocate of the resident? ☐ 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?
☐ Yes ☐ No

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

_____

_____

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 spend a minimum of three hours each month in the assigned facility visiting residents, keep a journal of resident visits, and report identified concerns and resolutions for resident problems to the VOP Coordinator.

I agree to complete an additional ten hours of training in the first year of assignment and six hours of training 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 VOP Coordinator 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 _____

Mail completed application to:

Volunteer Ombudsman Program Coordinator

Iowa Dept. on Aging, Jessie M Parker Bldg., 510 E 12TH St, Rm 2, Des Moines, IA 50319