



## RRCS LONG-TERM CARE OMBUDSMAN PROGRAM VOLUNTEER APPLICATION

**INSTRUCTIONS:** Complete, print, and sign this (1) application, the (2) confidentiality agreement form, and the (3) DMV information request form. Complete, *but do not sign*, the (4) Department of Social Services Central Registry Release of Information Form. Email all these forms to Kathi Walker ([ombudsman@rrcsb.org](mailto:ombudsman@rrcsb.org)), Long-Term Care Ombudsman or mail to RRCS, ATTN: Kathi Walker, PO Box 1568, Culpeper, VA 22701.

### PERSONAL

Name: \_\_\_\_\_  
(last) (first) (middle)

Address: \_\_\_\_\_  
(street)  
\_\_\_\_\_  
(county) (city/town) (state) (zip)

Phone: \_\_\_\_\_  
(home) (work) (cell)

E-mail: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Are You Currently Employed? Full-time  Part-time  Retired  Seeking Employment

Current Employer Name: \_\_\_\_\_

Current Employer Address: \_\_\_\_\_

Current Employer Phone: \_\_\_\_\_

Briefly describe your current (or previous, if you are not currently working) employment responsibilities:

### VOLUNTEER EXPERIENCE

Have you ever been a volunteer? Yes  No  If yes, where? \_\_\_\_\_

Dates of service: \_\_\_\_\_ to \_\_\_\_\_

Briefly describe your duties and activities:

Do you have other volunteer experience? Yes  No  If yes, where? \_\_\_\_\_

Dates of service: \_\_\_\_\_ to \_\_\_\_\_

Briefly describe your duties and activities:



## RRCS LONG-TERM CARE OMBUDSMAN PROGRAM VOLUNTEER APPLICATION

### EDUCATION/INTERESTS

What is the highest level of education you have attained?

High School  College/Other Post High School Education  Advanced Degree

Do you speak any foreign languages? If yes, please specify: \_\_\_\_\_

### LONG-TERM CARE FACILITY EXPERIENCE

Have you had any experience with long-term care facilities?

Yes  No  If yes, please describe below:

Have you had any experience working with the elderly?

Yes  No  If yes, please describe below:

Do you or a family member work in, or own, a nursing home or assisted living facility?

Yes  No  If yes, please describe below:

Does a member of your family reside in a nursing home or assisted living facility now?

Yes  No  If yes, please provide the name and address below:

During the last five years, do you, or a member of your immediate family, have a business relationship with a long-term care facility or its affiliates? *A business relationship is established through employment or ownership, including partial ownership.*

Yes  No

Do you, or a member of your immediate family, have an investment interest (funds invested currently or in the past) in a long-term care facility or its affiliates?

Yes  No



# RRCS LONG-TERM CARE OMBUDSMAN PROGRAM VOLUNTEER APPLICATION

## OTHER

Do you drive? Yes  No  Do you have your own transportation? Yes  No

In case of emergency, please contact:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

## LOCAL REFERENCES

Please list the names and contact information for two references (not related to you), one of which is a professional contact (employer, teacher, minister, etc.). Complete address and (at least one) phone numbers is necessary.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

E-mail: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

E-mail: \_\_\_\_\_

How did you learn about this program?

**Volunteers are asked to make a renewable one-year commitment to this job.**

**Except for unexpected developments, are you willing and able to commit to the full one-year term for the program?** Yes  No

Please use additional pages if you wish to include any other, pertinent information in this application.

**I certify that the information given herein is accurate to the best of my knowledge. I understand that the references listed above will be contacted and that the sponsoring agency will do a records check on qualified applications. I consent to the release of all relevant information concerning my ability and fitness to work as a volunteer Long-Term Care Ombudsman. I understand that this information will be held in confidence and not released to any outside person or agency for any purpose other than to verify information.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Rappahannock Rapidan**  
*Community Services*  
**Programs that matter. People who care.**

**Administrative Offices**

P. O. Box 1568  
 Culpeper, VA 22701  
 Telephone: (540) 825-3100  
 FAX: (540) 825-6245

**Volunteer Confidentiality Statement**

We are pleased you are interested in volunteering for programs of Rappahannock Rapidan Community Services (RRCS). As you take on this very important role, we want to provide information to you related to confidentiality so that each person who provides service at our programs will understand the importance of this issue and the privacy rights of our volunteers and clientele.

Confidentiality is a set of rules or a promise that limits access or places restrictions on certain types of information. In addition, it means to keep a confidence between the client, employees and volunteers. It is also important not to show anyone an individual's personal records or share any information about clients, employees, or fellow volunteers via any social media outlets without written permission from the person.

Volunteers may observe many needs and challenges clientele are dealing with. They are also privy to private personal information due to the nature of the programs RRCS serves. It is imperative that information shared with you is kept strictly confidential. In this way, we can protect the privacy of all clientele.

If you think you need to report concerns you may have about specific individuals or the program as a whole, feel free to share these concerns with the volunteer coordinator of RRCS at extension 3358. We request that volunteers not speak of these concerns in front of others at any time.

RRCS registered volunteers' information will also remain confidential. Your personal information is not shared with anyone other than specific RRCS program staff and the Department of Aging and Rehabilitative Services (DARS). Monthly reporting on volunteer activity at RRCS Programs is required with our state office DARS. Like us, DARS will keep all information confidential.

If you have any questions related to confidentiality, please do not hesitate to ask the volunteer coordinator of RRCS at 540-825-3100 x3358.

I have read and understand the confidentiality statement for providing volunteer service at Rappahannock Rapidan Community Services.

Name (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Search Fee \$10.00**

**Purpose of Search, Check one:**  Adam Walsh Law  Adoptive Parent  Babysitter/Family Day Care  
 CASA  Children’s Residential Facility  Custody Evaluation  Day Care Center  Foster Parent  
 Institutional Employee  Other Employment  School Personnel  Volunteer  Other

**MAIL SEARCH RESULTS TO: Agency, Individual or Authorized Agent Requesting Search**

Name			Payment/FIPS Code (Use only if assigned by OBI-CRU)		
Address					
City	State	Zip			
Contact Name	Tel.#	Ext			
Contact E-Mail	Mandatory if agency code has been assigned				

**PART I: DETAILS OF INDIVIDUAL WHOSE NAME MUST BE SEARCHED**

Last Name	First Name	Full Middle Name – (given at birth) - <b>No initials</b> (if middle name is an initial, indicate "Initial Only")			
Maiden Name (last name before marriage)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY)	Race		
Driver’s License Number or ID #	Social Security Number	Other names used; nicknames, legal names (refer to instruction page)			
Current Address (Include Street # and Apt #)	City	State	Zip		

**Applicant’s Prior Addresses**

Include Street # and Apt #	City	State	Zip	Start Date (MM/YY)	End Date (MM/YY)

**Marital Status** Single Married Divorced Widowed Partner

If married, list current spouse. If previously married, list all previous spouses. If you have never been married, write 'N/A'.

Last Name	First Name	Full Middle Name (given at birth)	Maiden Name	Race	Sex	Date of Birth (MM/DD/YYYY)
					<input type="checkbox"/> Male <input type="checkbox"/> Female	
					<input type="checkbox"/> Male <input type="checkbox"/> Female	
					<input type="checkbox"/> Male <input type="checkbox"/> Female	

**List all of your children.** If you have none, write 'N/A'. Include all adult children, step and foster children not living with you.

Last Name	First Name	Full Middle Name (given at birth)	Relationship	Sex	Date of Birth (MM/DD/YYYY)
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	



**Search Fee \$10.00**

**PART II: CERTIFICATION AND CONSENT FOR RELEASE OF INFORMATION**

I hereby certify that the information contained on this form is true, correct and complete to the best of my knowledge. Pursuant to Section 2.2-3806 of the *Code of Virginia*, I authorize the release of personal information regarding me which has been maintained by either the Virginia Department of Social Services or any local department of social services which is related to any disposition of founded child abuse/neglect in which I am identified as responsible for such abuse/neglect. I have provided proof of my identity to the Notary Public prior to signing this in his/her presence.

\_\_\_\_\_  
Signature of person whose name is being searched  
(Sign in presence of Notary)

\_\_\_\_\_  
Parent or Guardian signature required for minor  
children under the age of 18

**PART III: CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL**

City/County of \_\_\_\_\_  
Commonwealth/State of \_\_\_\_\_  
Acknowledged before me this \_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_\_

\_\_\_\_\_  
**Notary Public Signature** ..... **Notary Number**  
My Commission Expires: \_\_\_\_\_

Notary Seal

**PART IV: CENTRAL REGISTRY FINDINGS – COMPLETED BY CENTRAL REGISTRY STAFF ONLY**

1. We are unable to determine at this time if the individual for whom a search has been requested is listed in the Central Registry. Please answer the following questions and return to the Central Registry Unit in order for us to make a determination:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Worker: \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_ Based on information provided by the Local Department of Social Services, we have determined that \_\_\_\_\_ is listed in the Child Abuse/Neglect Central Registry with a founded disposition of child abuse/neglect. For more detailed information, contact the

\_\_\_\_\_ Dept. of Social Services in reference to referral \_\_\_\_\_ phone# \_\_\_\_\_

\_\_\_\_\_ Dept. of Social Services in reference to referral \_\_\_\_\_ phone# \_\_\_\_\_

3. \_\_\_\_ As of this date, based on the information provided, the individual whose name was being searched is **NOT** identified in the Central Registry of Child Abuse/Neglect.

Signature of worker completing search: \_\_\_\_\_ Date: \_\_\_\_\_

OBI Staff Only