VOLUNTEER APPLICATION

Wendy Hutterer, Department Director
wendyhutterer@manitowoccountywi.gov

Manitowoc County Office: 1701 Michigan Avenue Manitowoc, WI 54220
Kewaunee County Office: 810 Lincoln Street Kewaunee, WI 54216
Phone: 920-683-4180 Fax: 920-683-2718 Toll Free: 1-877-416-7083

Section A – To be completed by the ADRC staff

Department:
- ☐ Aging/ADRC/Nutrition Program; Site: _____
- ☐ Driver - Nutrition Program, Site: _____
- ☐ Driver - Transportation Program
- ☐ Facilitator
- ☐ General/Office
- ☐ Open Enrollment

☐ This volunteer will be responsible for providing services to the public without a County employee being present.

Referred By: _____

Section B – To be completed by volunteer.

To Volunteer Applicant: in volunteering for the ADRC of the Lakeshore and we assure you that we are interested in your qualifications. The ADRC of the Lakeshore does not discriminate on the basis of race, color, religion, national origin, sex, age, marital or veteran status, the presence of a disability, or any other legally protected status.

PERSONAL INFORMATION

Name (Please Print):
Address:
Phone Number: Date of Birth:
Social Security Number:
Ethnicity: ☐ White ☐ Black ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native
Gender: ☐ Male ☐ Female
Email:

DRIVER INFORMATION - *Only complete if you will be a driving for the ADRC.*

Driver's License Number:
Driver's License Expiration:
If applying for a driver position, a copy of your automobile insurance is required. *A W9 Form will need to be completed and attached if you will be claiming gas mileage.*

REFERENCES:			
Name	Address	Telephone	Relationship
Name	Address	Telephone	Relationship
IN CASE OF EMERGENCY PLEASE NOTIFY			
Name	Address	Telephone	Relationship
Name	Address	Telephone	Relationship

SIGNATURE

My signature below certifies that all statements made on this application are true, complete and correct to the best of my knowledge and belief. I understand that these statements are subject to verification. I understand that falsification of this application may disqualify me from consideration or result in my dismissal upon discovery. Furthermore, my signature below authorizes Manitowoc County to conduct motor vehicle checks as well as reference checks to determine my suitability for placement and I hereby release all parties from liability for any information provided in response to such inquiries. I understand that any information obtained by Manitowoc County from such parties is confidential and will not be released to me under any circumstances or in any form whatsoever. A copy of this authorization is as valid as an original.

_____ _____

Signature Date

Office Use Only:
❒ Approved ❒Not Approved
Initials: _____
Date: _____
❒ Entered in SAMS Initials:_____
❒Meal Site Manager Notified Initials _____

Confidentiality Statement

Purpose of Confidentiality Statement:

Manitowoc County is required by federal and state law to protect the privacy of it's Clients and their medical information. The Aging & Disability Resource Center of the Lakeshore, its staff and volunteers involved in carrying out its mission, will respect the rights of its clients and their medical needs.

While information on clients of the Aging & Disability Resource Center of the Lakeshore may not be Considered protected health information, the Aging & Disability Resource Center of the Lakeshore will treat client records as confidential and its volunteers and staff will be provided only information that is "need to know" in order to provide services to clients of the Aging & Disability Resource Center of the Lakeshore. This information is confidential between the responsible party overseeing the services being provided and the provider of the services.

Confidentiality Statement:

To maintain the confidentiality of clients and the services they are receiving, the provider of services shall not discuss with others names or conditions of clients receiving services through the Aging & Disability Resource Center of the Lakeshore.

The provider of services shall report back to their responsible party overseeing the services any client situations that may present a threat to the health or safety of that client.

Medical information may be shared with a family member, personal representative, or other person responsible for the client's care if it is necessary to notify such persons of their location, general condition, or death.

I have reviewed and understand the Aging & Disability Resource Center of the Lakeshore Confidentiality Statement and will respect the privacy and rights of the Aging & Disability Resource Center of the Lakeshore's clients.

PRINT NAME: _____

_____ _____

SIGNATURE **Date**

Media Release

The Aging and Disability Resource Center (ADRC) of the Lakeshore has my permission to use my or my child's photograph or video publically to promote the ADRC of the Lakeshore. I understand that the images may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

Signature: _____ Date: _____

Name (please print): _____

Address: _____

Signature of parent or legal guardian: _____
(if under 18 years of age)