

Medicare Information Office

STATE HEALTH INSURANCE PROGRAM/SENIOR MEDICARE PATROL APPLICATION

DATE: _____

THANK YOU FOR YOUR INTEREST IN BECOMING AN ALASKA SHIP/SMP VOLUNTEER OR PARTNER AGENCY. WE PROVIDE FREE, UNBAISED, CONFIDENTIAL COUNSELING TO ANYONE WITH QUESTIONS ABOUT MEDICARE.

NAME (LAST, FIRST MI):	EMAIL ADDRESS:	
PHONE NUMBERS:		
ADDRESS (INCLUDE ZIP CODE):		
AGENCY AFFILIATION (IF ANY)		
LANGUAGES SPOKEN	LANGUAGES READ	LANGUAGES WRITTEN
EMERGENCY CONTACT		
NAME:	PHONE:	RELATIONSHIP:

REFERENCES:

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____

AREAS OF INTEREST WITHIN OUR VOLUNTEER ROLES: (PLEASE CHECK ALL THAT APPLY)

- | | | |
|---|--|---|
| <input type="checkbox"/> COUNSELING | <input type="checkbox"/> ASSISTING WITH ADMINISTRATION | <input type="checkbox"/> STAFFING EXHIBITS |
| <input type="checkbox"/> MAKING GROUP PRESENTATIONS | <input type="checkbox"/> HANDLING COMPLEX ISSUES | <input type="checkbox"/> DISTRIBUTING INFORMATION |
| <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____ | | |

IF APPLYING FOR VOLUNTEER ROLE, HOW OFTEN WOULD YOU LIKE TO VOLUNTEER?

HOW MANY HOURS ARE YOU AVAILABLE FOR VOLUNTEER ASSIGNMENTS?

HOURS PER WEEK: _____ HOURS PER MONTH: _____

CHECK THE DAYS AND TIMES YOU ARE AVAILABLE FOR VOLUNTEER ASSIGNMENTS.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
MORNINGS					
AFTERNOONS					

HOW DID YOU HEAR ABOUT VOLUNTEERING AT THE MEDICARE INFORMATION OFFICE?

- WEBSITE NEWSPAPER WORD OF MOUTH COMMUNITY PRESENTATION
 FRIEND/RELATIVE RADIO/TV AD OTHER (EXPLAIN): _____

DO YOU HAVE ANY PHYSICAL LIMITATIONS? _____. IF YES, PLEASE EXPLAIN,

BACKGROUND CHECK POLICY

THE MEDICARE INFORMATION OFFICE CONDUCTS BACKGROUND CHECKS ON ALL APPLICANTS FOR VOLUNTEER POSITIONS THAT INVOLVE PEOPLES' PERSONAL, MEDICAL, AND FINANCIAL INFORMATION, INCLUDING A CRIMINAL RECORDS CHECK AND SEX OFFENDER REGISTRY SEARCH. HAVE YOU EVER BEEN CONVICTED OF ANY CRIMES, FELONIES, OR MISDEMEANORS? _____No _____Yes

IF YES, PLEASE EXPLAIN. _____

Authorization and Certification

I certify that the information I provided in this application is true, complete, and accurate to the best of my knowledge. I also authorize the Medicare Information Office to contact the references named below with regard to my application to become a volunteer. I also authorize the persons referenced to provide information in connection with my application, and release them from any liability in regard to it.

Signature: _____ Date: _____

EMAIL, FAX OR MAIL COMPLETED APPLICATION TO:

HSS.MEDICARE@ALASKA.GOV • P.O. Box 240249, ANCHORAGE, AK 99524-0249

FAX: (907) 269-2045 • PHONE: 1-800-478-6065 OR (907) 269-3680

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