

**ALASKA MEDICARE INFORMATION OFFICE
STATE HEALTH INSURANCE PROGRAM/SENIOR MEDICARE PATROL
VOLUNTEER APPLICATION**

DATE: _____

THANK YOU FOR YOUR INTEREST IN BECOMING AN ALASKA SHIP VOLUNTEER. 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		

REFERENCES:

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____

AREAS OF INTEREST: (PLEASE CHECK ALL THAT APPLY)

- HELP WITH MAILINGS
 ONE ON ONE COUNSELING
 TEACHING/TRAINING
 ASSIST WITH WEBSITE UPKEEP
 DATA ENTRY
 PUBLIC SPEAKING WITH SMALL GROUPS
 ORGANIZE OUTREACH EVENTS
 PUBLIC SPEAKING WITH LARGE GROUPS
 PHONE CALL DATA VERIFICATION
 ASSIST WITH MEDICARE CLAIMS
 VOLUNTEER COORDINATION
 DATABASE UPKEEP
 GENERAL OFFICE WORK
 OTHER (SPECIFY) _____

HOW OFTEN WOULD YOU LIKE TO VOLUNTEER?

REGULARLY: AVAILABLE _____ HOURS A WEEK DURING THE:
 CHECK YOUR PREFERENCE: MORNING AFTERNOON EVENING

OCCASIONALLY:
 CHECK YOUR PREFERENCE: FOR SPECIAL EVENTS PERIODICALLY DURING CERTAIN TIMES OF THE YEAR
 (SPECIFY)(I.E. SUMMER, HOLIDAYS) _____

HOW DID YOU HEAR ABOUT VOLUNTEERING AT THE MEDICARE INFORMATION OFFICE (SHIP)

- WEBSITE
 NEWSPAPER
 WORD OF MOUTH
 COMMUNITY PRESENTATION
 FRIEND/RELATIVE
 RADIO/TV AD
 OTHER

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

CONFIDENTIALITY POLICY

I, _____ SERVING AS A SHIP AND/OR SMP VOLUNTEER FOR THE STATE OF ALASKA, DEPT. OF HSS, MEDICARE INFORMATION OFFICE, HAVE TAKEN AN OATH OF CONFIDENTIALITY AND AGREE TO THE FOLLOWING:

IN MY POSITION AT THE MEDICARE INFORMATION OFFICE, I PROMISE TO PROTECT THE IDENTITY AND CONFIDENTIALITY OF ANY PERSON I SPEAK TO OR COUNSEL. I WILL NEVER DISCLOSE INFORMATION ABOUT A CLIENT, FAMILY, OR PROVIDER WITHOUT THE WRITTEN CONSENT OF THE PERSON INVOLVED. IF INFORMATION NEEDS TO BE EXCHANGED WITH MEDICARE INFORMATION OFFICE STAFF, IT WILL BE ON A NEED-TO-KNOW BASIS AND ONLY INCLUDE THE FACTS AND NEVER INVOLVE GOSSIP OR HEARSAY. AT NO TIME WILL I DISCUSS A CLIENT, FAMILY, OR HEALTHCARE PROVIDER IN PUBLIC OR PRIVATE CONVERSATIONS.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT'S (HIPPA) "MINIMUM NECESSARY" PORTION OF THE PRIVACY NOTICE SUPPORTS THE ABOVE STATEMENTS.

_____ PRINTED NAME OF VOLUNTEER	_____ SIGNATURE OF VOLUNTEER	_____ DATE & TIME SIGNED
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RELEASE OF INFORMATION

I UNDERSTAND A BACKGROUND CHECK POSSIBLY INCLUDING FINGERPRINTING IS REQUIRED FOR VOLUNTEERING AT THE ALASKA MEDICARE INFORMATION OFFICE.

HAVE YOU EVER BEEN CONVICTED OF ANY CRIMES, FELONIES, AND MISDEMEANORS? ____ No ____ Yes

IF YES, PLEASE EXPLAIN. _____

_____ PRINTED NAME OF VOLUNTEER	_____ SIGNATURE OF VOLUNTEER	_____ DATE & TIME SIGNED
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EMAIL, FAX OR MAIL COMPLETED APPLICATION TO:

NILA.MORGAN@ALASKA.GOV • 400 GAMBELL ST. SUITE 303, ANCHORAGE, AK 99501

FAX: (907) 269-2045 • PHONE: 1-800-478-6065 OR (907) 269-4199

Medicare Information Office

