Position Title: Patient Care Volunteer

**General Statement of Duties:** Under the direction and supervision of the Manager of Volunteer Services and nursing staff, provides direct service to the patient/family. Services include emotional support, homemaking tasks, and companionship.

**Functions:**
1. Establishes a friendly relationship with assigned patient and family.
2. Makes periodic visits and phone calls to provide practical and emotional support.
3. Communicates regularly with the Manager of Volunteers and when needed, the staff assigned to patients.
4. Documents visits and pertinent information as directed by the Manager of Volunteer Services.
5. Maintains strict confidentiality about patients and families, as well as sensitive organizational matters.
6. Participates in continuing education and group volunteer activities.

**Requirements:**
1. Effective communication skills such as creative listening and sensitivity to non-verbal communication.
2. Knowledge of grief process.
3. Demonstrates willingness to work with the professional staff providing care.
4. Emotional maturity, stability, and confidence.
5. Sincere desire to help and adequate time to do so.
6. Non-judgmental attitude; ability to relate to a variety of people.
7. Willingness to perform mundane tasks.
8. Understanding and acceptance of Coastal Hospice philosophy and policies.
9. Completion of "Introduction to Hospice Care" or equivalent as determined by the Manager of Volunteer Services.
10. If using automobile for Coastal Hospice duties, a valid driver’s license and $100,000/$300,000 automobile liability insurance.

**Signature:** ___________________________________________ **Date:** ______________________
Guidelines for Patient Care Volunteers
Patient care volunteers are required to complete Introduction to Coastal Hospice (16-hour course) before they are given an assignment. If an applicant has documentation of attendance in a similar program elsewhere, that training will be reviewed and may be accepted with the approval of the Manager of Volunteer Services.

How to Apply
Call Volunteer Services at the Coastal Hospice office 410-543-2590 to make an appointment with the Manager of Volunteer Services. During the interview, you will discuss the type of service desired, hours available and other matters relating to volunteer services.

Coastal Hospice Offers
- Opportunities for meaningful community service
- Emotional support for any assigned task
- Fellowship and fun at volunteer gatherings
- Hepatitis B immunization

Volunteer will be asked to
Participate in at least one continuing education program yearly (provided by Coastal Hospice)
Have an annual PPD test
Refrain from the use of alcohol and tobacco while on assignment
Sign: Conflict of Interest, Confidentiality Agreement and Position Description
Complete a HIPAA post test
Consent to a background check
If needed provide your own transportation
Notify Volunteer Services of any change of availability or extended times of absence
Complete and return all record keeping forms promptly
Wear a name badge (provided by Coastal Hospice) when on assignment
Provide proof of current driver’s license, current auto insurance (if applicable)
Complete yearly updates and evaluation

Duties, Functions and Requirements of a Patient Care Volunteer are listed on the Patient Care Volunteer position description.

Assignments of Patient Care Volunteers
All volunteer assignments are made through the Volunteer Services office. Volunteers typically spend two to three hours per visit depending on the needs of the patient and family. Whenever possible, volunteers will be asked well in advance. Volunteer Services will supply basic patient information to the volunteer. Volunteer Services will assign substitutes to fill the place of a volunteer who is excused.

Emergencies and Special Medical Problems
When an emergency occurs in the home of a hospice patient the volunteer will always call the office at 410-742-8732. If a patient is FULL CODE, the volunteer should call 911, then call Coastal Hospice. If necessary, the nurse will visit the family or contact the appropriate team member or community resource for help.
VOLUNTEER APPLICATION

PERSONAL INFORMATION

Date: _______________________

Name: ______________________________________________________________________________

Address: ____________________________________________________________________________

Phone Number: (H) _______________ (W) ____________________ (other)______________________

Email: ______________________________________________________________________________

We would like to recognize your birthday if you care to share the date___________________________

Notify in case of emergency: Name_________________________________ Relationship___________

Address: ________________________________________Phone Number: ______________________

Current Occupation: _______________________ Place of Employment: ________________________

Referred by: ________________________________________________________________________

If you possess a license, certificate or registration as a result of specialized education or training, please complete the following:

Title: _______________________ License or Registration No.: _____________ State: ____________

Date Issued: ___________________________ Date of Expiration: ____________________________

Do you carry professional liability insurance?       Yes ☐       No ☐

Have you ever been convicted of a felony?        Yes ☐       No ☐

OTHER WORK EXPERIENCE (include paid and volunteer)

__________________________________________________________________________________

EDUCATION (include continuing education or special training)

__________________________________________________________________________________

Coastal Hospice & Palliative Care
PO Box 1733       Salisbury, MD 21802       410-742-8732       www.coastalhospice.org

V:\Volunteer packet forms\Volunteer Application revised May 2016.doc
SPECIAL SKILLS (foreign language, typing, hobbies, etc.)

What hours and days are you generally available?

The following information is needed to provide excess coverage over your personal insurance if you are using your vehicle while in the course of Coastal Hospice business:

Driver’s License No.________________________ State____________

Attach a copy of your auto insurance certificate, which states the limitations of coverage. Updated certificates must be furnished as issued.

WORK PREFERENCE: Please indicate the type of volunteer work you would like to perform at Coastal Hospice:

REFERENCES: Please list three people we may contact.

I hereby authorize Coastal Hospice, Inc., to ascertain any and all information which may be pertinent to my volunteer duties. I release any individual from all liability for damages that may result to me on attempts of compliance or any attempts to comply with this authorization.

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Signature of Volunteer ___________________________ Date __________

Please complete and return to:
Sally Rankin, Manager of Volunteer Services
Coastal Hospice & Palliative Care
PO Box 1733
Salisbury, MD 21802
410-543-2590
Initial Volunteer Survey

Name ______________________________ Date __________________

Address_______________________________________________________________________

Home Phone ____________________ Work Phone _________________________________

Cell Phone _____________________ E-mail Address _____________________________

I would like the following phone number as my primary contact _________________

We would like to recognize your birthday if you care to share the date____________________

I am a Veteran ___Yes ___No

I am interested in the following (check all that apply)

___Clerical/Reception (choose any of the following locations)
___Coastal Hospice Offices (Salisbury) ___Coastal Hospice at the Lake (Salisbury)
___Coastal Hospice at the Ocean (Berlin)
___Home Hospice Patient care (including facilities such as nursing homes, group homes)
___Assigned a patient for ongoing needs ___Prefer no children
___Assigned a patient for single visit/short term ___Prefer non-smoking
___Prefer no pets
___Coastal Hospice at the Lake (Salisbury) ___Patient Care
___Thrift Shop (Berlin)
___Transportation ___I will travel outside the county in which I live
___Deliveries ___I will travel outside the county in which I live
___Bereavement ___ phone calls ___ letters
___Mailings
___Office Assistance ___ computer ___ phones ___ filing
___Special Events (Memorial Services, parties)
___Fundraising ___Public Relations (Health Fairs)
___Hospitality (prepare refreshments) ___Gardening
___Meal Preparation for Patients ___Other _______________________________________

Please return survey with application. Thank you!