Central Massachusetts Agency on Aging
www.SeniorConnection.org

VOLUNTEER OMBUDSMAN APPLICATION

PLEASE PRINT OR TYPE ALL INFORMATION:

Date: _____

Full Name: _____

Current Address: _____

Mailing Address (if different): _____

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

Is it okay to text?: YES NO

EXPERIENCE:

What is your current work experience?: _____

_____

_____

Special skills or interests: _____

_____

Please list any previous volunteer experience: _____

_____

PRE-REQUISITES/REQUIREMENTS:

Why do you want to become a certified volunteer ombudsman?: _____

_____

How did you learn about this program?: _____

All volunteer ombudsman must be trained & certified by The Commonwealth of Massachusetts. Will you be able to attend the entire training program?: YES NO (*Due to COVID, the 3-day training is scheduled via video in 2-3 hour modules until training is complete*).

Ombudsman are required to attend monthly meeting/training to maintain certification. Will you be able to attend?: YES NO
(Due to COVID, monthly meetings are done via video/telephone).

Do you have reliable transportation for visiting assigned facilities and attending meetings?: YES NO

Are you vaccinated? If so, what dates did you receive doses?: _____

_____

If you are vaccinated, have you had a booster? If so, what date?: _____

PROVIDE 2 REFERENCES NOT RELATED TO YOU:

Name:_____ **Telephone**:_____
Mailing Address: _____
Relationship: _____

Name:_____ **Telephone**:_____
Mailing Address: _____
Relationship: _____

EMERGENCY CONTACT:

Name:_____ **Telephone**:_____
Email Address: _____
Relationship: _____

I ATTEST THE ABOVE IS TRUE:

_____ _____
APPLICANT SIGNATURE **DATE**

VOLUNTEER OMBUDSMAN APPLICATION–CONFLICT OF INTEREST CLAUSE

PLEASE PRINT OR TYPE ALL INFORMATION:

Date: _____

Applicant Full Name: _____

Mailing Address: _____

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

Is it okay to text?: YES NO

1. **Do you, or any member of your family, hold any type of financial interest in any long-term care facility? YES NO**

   If YES, explain: _____

   _____

2. **Have you, or any member of your family, been employed in a long-term care facility?: YES NO**

   If YES, explain: _____

   _____

3. **Do you have any family members currently residing in a nursing home or rest home?: YES NO**

   If YES, explain: _____

   _____

4. **Do you have any family members currently residing in a nursing home or rest home?: YES NO**

   If YES, explain: _____

   _____

I understand that the Massachusetts State Long Term Care Ombudsman has the authority to decertify my position as an Ombudsman Representative at any time if I do not meet the qualifications, guidelines or expectations as stated in the Older Americans Act, Massachusetts statutes and regulations, and Massachusetts Long Term Care Ombudsman policies, procedures and guidelines.

As a representative of the State Ombudsman, I will protect a resident's right to privacy and not disclose any confidential information outside the Ombudsman Program.

For the wellbeing of the residents I served as an Ombudsman, I understand after separation from the Ombudsman Program, I may not visit the home(s) I served as an Ombudsman in any capacity for a period of 12 months, except to visit a family member or friend with their informed consent.

I CERTIFY THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE, COMPLETE, AND CORRECT:

_____ _____

APPLICANT SIGNATURE **DATE**