Certified Volunteer Long-Term Care Ombudsman Application

Name: _____

Address: _____

City, Zip Code: _____

Preferred phone number: _____

Secondary phone number: _____

Email: _____

Best time available to contact you? _____

Are you at least 18 years of age? ☐ Yes ☐ No

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Other

Employer and/or school within last five years:

_____

_____

How did you learn about the Volunteer Ombudsman opportunity?

_____

_____

Why do you want to be a Volunteer Ombudsman?

_____

_____

List/describe your past and present volunteer experiences.

_____

_____

_____

Describe any skills or strengths you have that would be valuable to the VOP.

_____

_____

Are you able to use computer software such as Google and Microsoft Word?

_____

_____

Do you speak any languages other than English? ☐ Yes ☐ No
If yes, what is your level of fluency? _____

Will you be able to spend a minimum of three hours every month visiting an assigned facility? ☐ Yes ☐ No

Will you be able to complete 36 hours of certification training? ☐ Yes ☐ No

Will you be able to commit to at least one year of volunteer service? ☐ Yes ☐ No

If no, are you a college student or seasonal traveler who spends several months in another state during the year? ☐ Yes ☐ No

Would you be able to commit to at least nine months of volunteer service to the Volunteer Ombudsman Program? ☐ Yes ☐ No

To maintain certification, volunteers must complete up to 18 hours of continuing education (provided by the OSLTCO) each year. Are you willing to complete this requirement to maintain certification? ☐ Yes ☐ No

Will you be able to provide your own transportation? ☐ Yes ☐ No

All Volunteer Ombudsmen will need to pass a comprehensive criminal background check before their service begins. Are you willing to consent to a criminal history records check? ☐ Yes ☐ No

In addition to your regular Volunteer Ombudsman duties, would you be interest in helping with administrative projects (Des Moines office)? ☐ Yes ☐ No

Emergency Contact Information

In the event that you become a certified volunteer ombudsman we will need to know who we should notify in case of an emergency.

Name: _____ Relationship: _____

Phone: _____ Email: _____

IMPORTANT – PLEASE READ

If I am accepted as a Certified Volunteer Long Term Care Ombudsman, I agree to read the volunteer training manual and participate in orientation prior to beginning my volunteer duties.

I consent to the posting of my name and photo at the designated facility.

I agree to volunteer no less than three hours per month advocating for residents in my assigned facility. I agree to submit reports in a timely fashion and be responsive to communication from program staff.

I understand that in order to maintain certification I must complete the required hours of continuing education in the first year of assignment and each year thereafter.

I understand that failure to fulfill these responsibilities may result in termination of volunteer duties.

VOLUNTEER PROGRAM

I understand that I am applying to be a Certified Volunteer Long Term Care Ombudsman for the Department of Health and Human Services, Office of the State Long Term Care Ombudsman.

My volunteer work will be conducted in a long-term care facility, but I understand that I am NOT a volunteer for the facility.

I understand that I can contact the Office of the State Long-Term Care Ombudsman at any time for information or assistance and that contacts and referral procedures will be spelled out in my training.

By signing this application, I verify that all information is true and correct; I understand the responsibilities associated with this volunteer position and agree to abide by these terms.

Signature: _____ Date: _____

(or full legal name if signing electronically)

Mail completed application to: sltco@hhs.iowa.gov

or

Office of the State Long-Term Care Ombudsman

Division of Compliance

321 E 12th St, 2nd Floor

Des Moines, IA 50319

Code of Ethics for Long-Term Care Ombudsman

The National Association of State Long Term Care Ombudsman Programs

1. The ombudsman provides services with respect for human dignity and the individuality of the client, unrestricted by considerations of age, social or economic status, personal characteristics, or lifestyle choices.

2. The ombudsman respects and promotes the client's right to self-determination.

3. The ombudsman makes every reasonable effort to ascertain and act in accordance with the client's wishes.

4. The ombudsman acts to protect vulnerable individuals from abuse and neglect.

5. The ombudsman safeguards the client's right to privacy by protecting confidential information.

6. The ombudsman remains knowledgeable in areas relevant to the long-term care system, especially regulatory and legislative information, and long-term care service options.

7. The ombudsman acts in accordance with the standards and practices of the Long-Term Care Ombudsman Program, and with respect for the policies of the sponsoring organization.

8. The ombudsman will provide professional advocacy services unrestricted by his/her personal belief or opinion.

9. The ombudsman participates in efforts to promote a quality, long term care system.

10. The ombudsman participates in efforts to maintain and promote the integrity of the Long-Term Care Ombudsman Program.

11. The ombudsman supports a strict conflict of interest standard that prohibits any financial interest in the delivery or provision of nursing home, board, and care services, or other long-term care services that are within their scope of involvement.

12. The ombudsman shall conduct himself/herself in a manner that will strengthen the statewide and national ombudsman network.

I have received and agree to abide by this code of ethics.

_____ _____

Signature of Representative Date

_____ _____

State Long-Term Care Ombudsman Date

Office of the State Long-Term Care Ombudsman
Conflicts of Interest Form

1. Do you or any of your immediate family members currently work, or have previously worked for a managed care organization, long term care facility, assisted living program or elder group home, or participated in the management, ownership, or operation of that entity within the previous year? ☐Yes ☐No

   If yes, please provide the name of the entity, the position held, and the duties associated with this role:

   _____

2. Have you or any of your immediate family members owned, operated, or had any investment interest in any existing or proposed managed care organization, long term care facility, assisted living program, elder group home or of a provider of long-term care service in the previous two years? ☐Yes ☐No

   If yes, please explain: _____

3. Have you or any of your immediate family members been involved in the licensing, surveying or certification of a managed care organization, long term care facility, assisted living program, elder group home or of a provider of long-term care service in the previous one year? ☐Yes ☐No

   If yes, please explain: _____

4. Have you or any of your immediate family members received, or have the right to receive remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility or a managed care organization within the previous two years? ☐Yes ☐No

   If yes, please explain: _____

5. Have you or any of your immediate family members received any form of payment, gift, or gratuity of significant value from a managed care organization, long term care facility, assisted living program, elder group home, operator, resident, member or resident/member representative in the previous two years? ☐Yes ☐No

   If yes, please explain: _____

6. Have you accepted money or any other consideration from anyone other than an entity approved by the SLTCO for the performance of the Office of the State Long-Term Care Ombudsman program duties with the previous two years? ☐Yes ☐No

   If yes, please explain: _____

7. Have you provided a provision of service with an outside employer that may conflict with the duties of a Representative of this Office within the previous one year? ☐Yes ☐No

   If yes, please explain: _____

8. Have you or any of your immediate family members provided services to residents of a long-term care facility, assisted living program or elder group home or to members of a managed care organization in which a member of your immediate family resides within the previous two years? ☐Yes ☐No

   If yes, please explain: _____

9. Have you served in a role with management responsibility for, or operated under the supervision of, an individual with management responsibility for Adult Protective Services (APS) within the previous year? ☐Yes ☐No

   If yes, please explain: _____

10. Within the previous year, have you or any of your immediate family members served as a guardian, surrogate decision-maker, or in another fiduciary capacity in an official role (as opposed to serving in such a role in a personal capacity) for a resident of a long-term care facility, assisted living program or elder group home or for a member of a managed care organization? ☐Yes ☐No

    If yes, please explain: _____

11. Have you or any of your immediate family members or friends resided in a long-term care facility, assisted living program or elder group home within the previous two years? ☐Yes ☐No

    If yes, please provide the name and location of the entity:

    _____

12. Have you or any of your immediate family members participated in activities which could negatively affect your ability to serve residents/Medicaid members, or which are likely to create a perception that your primary interest is other than as an advocate of the resident/member within the previous year? ☐Yes ☐No

    If yes, please explain: _____

13. Do you have part-time employment that would create the perception that you could not advocate for residents or Medicaid members? ☐Yes ☐No

    If yes, please provide the name and location of your employer and include your job title and responsibilities:

    _____

14. Have you had a founded child or dependent adult abuse report against you since your initial certification as a Representative of the Office? ☐Yes ☐No

    If yes, please provide additional information:

    _____

15. Have you had a criminal conviction against you since your initial certification as a Representative of the Office? ☐Yes ☐No

    If yes, please provide additional information:

    _____

Name (printed): _____

Signature: _____

Date: _____ *Reviewed on:* _____ *Reviewed on:* _____ *Reviewed on:* _____

**Please note when answering the questions: Immediate family means a member of the household or a relative with whom there is a close personal or significant financial relationship.*

IOWA Health and Human Services

Request & Acknowledgement to Conduct Registry and Record Check

Disclosure Authorization

Please Read Carefully. We truly welcome your application with **Iowa Department of Health and Human Services (HHS).** You are applying for a position whose acceptance will place you in a category of recognized professionals. In pursuit of that excellence we require, as a condition of employment, that all applicants consent to and authorize a pre-employment and/or continued employment verification of their background, including information submitted on their application or resume.

I understand and acknowledge that the Iowa Department of Health Human Services (hereinafter "Department") is required by statute to conduct Child Abuse Registry, Dependent Adult Abuse Registry, Sexual Offender Registry checks and Criminal History Record checks for specific categories of persons who have direct contact with the Department's clients, provide Department approved services for the Department's clients or have access to IRS Federal Tax Information and hereby request the Department conduct such a Registry and/or Record check regarding me.

Information Required for Registry and Record Check (Please type or print legibly.)

Last Name	First Name	Middle Name	Maiden Name (if applicable)
Alias (if applicable)	Alias (if applicable)	Alias (if applicable)	Alias (if applicable)
Date of Birth	Sex	Social Security Number	Reason for Check
Address			
City	State	ZIP	
Personal Email Address			

☐ This is an FTI check. ☐ This is an initial check. ☐ This is a renewal or recheck.

For HHS Supervisors/Managers **only**	
Position (Official State Title)	Supervisor
Office Name and Address (include city, state, ZIP)	
HHS Division, Region	
Position Number	OCA Code

For HHS – HR Use **only**
Date Docs Received
Date Docs Received

Criminal History Record

I hereby request and give permission to the Department to conduct a Criminal History Record check.

Disclosure: This document serves solely as a clear and conspicuous written disclosure as required by the Federal Fair Credit Reporting Act set forth in Section 604 (b) to the applicant that a social security number trace, motor vehicle verification, education, previous employment, credit and a criminal background verification may be obtained for the purpose of this employment application. In addition, investigative consumer reports gathered from personal interviews with former employers and other past or current associates of mine to gather information regarding my work performance, character, general reputation and personal characteristics may be obtained for the purpose of this employment application. By the signature below, the Applicant acknowledges that Global Screening Solutions Inc. has made this disclosure.

Applicant Authorization and Consent for Release of Information: This release and authorization acknowledges that HHS may now, or any time while I am employed/training, conduct a verification of my education, previous employment/work history, credit history, contact personal references, motor vehicle records, conduct drug testing and to receive any criminal history information pertaining to me which may be in the files of any Federal, State, or Local criminal justice agency, and to verify any other information deemed necessary to fulfill the job requirements. The results of this verification process will be used to determine employment/training eligibility under HHS employment/training policies. In the event that information from the report is utilized in whole or in part in making an adverse action decision with regard to your potential employment/training, before making the adverse decision, we will provide you with a copy of the consumer report and a description in writing of your rights under the law. I authorize Global Screening Solutions Inc. at 4833 Front St., Suite B PMB 448, Castle Rock, CO 80104-7901, telephone number 866-454-2325 and any of its agents, to disclose orally and in writing the results of this verification process to the designated authorized representative HHS. Contact Global Screening Solutions Inc. if you want to receive a copy of our Information Security Policy.

I have read and understand this disclosure, and I authorize the background verification. I authorize persons, schools, current and former employers, and other organizations and Agencies to provide Global Screening Solutions, Inc. with all information that may be requested. I agree that any copy of this document is as valid as the original. According to the Federal Fair Credit Reporting Act, I am entitled to know if employment/training was denied based on information obtained by my prospective employer/training program and to receive a disclosure of the public record information and of the nature and scope of the investigative report.

Signature	Date

Child Abuse Registry

I hereby request and give permission to the Department to conduct a Child Abuse Registry check. I understand that my signature authorizes the requestor to receive information to verify whether I am named on the Child Abuse Registry as having abused a child (Iowa Code section 235A.15). To the best of my knowledge, the information contained in this form is correct.

Signature	Date

Dependent Adult Abuse Registry

I hereby request and give permission to the Department to conduct a Dependent Adult Abuse Registry check. I understand that my signature authorizes the requestor to receive information to verify whether I am named on the Dependent Adult Abuse Registry as having abused a dependent adult (Iowa Code section 235B.6). To the best of my knowledge, the information contained in this form is correct.

Signature	Date

Sexual Offender Registry

I hereby request and give permission to the Department to conduct a Sexual Offender Registry check.

Signature	Date

The Department will perform the following check **for State-Operated Facilities Only**

List of Excluded Individuals/Entities (LEIE)

LEIE is a database providing information to public health care providers, patients, and others relating to parties excluded from participation in the Medicare, Medicaid, and all Federal health care programs.

The Department will perform the following check **for State-Operated Facilities Only**

Excluded Parties List System (EPLS)

EPLS is a database which includes information regarding entities debarred, suspended, proposed for debarment, excluded, or disqualified under the non-procurement common rule, or otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits.

Background Check Information

Last Name	First Name	Date

Please list all addresses where you have lived, worked, or gone to school during the last **five** years below:

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Please attach additional sheets if necessary.