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

Name and town of the facility where you would like to serve as a Certified Volunteer Long-Term Care Ombudsman (if known)?

_____

_____

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, 4th 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 currently work, or have you 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. Do 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:

   _____

3. Have you owned, operated, or had any investment interest in any existing or proposed managed care organization, long term care facility, assisted living program, or elder group home in the previous two years? Yes No

   If yes, please explain: _____

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

   If yes, please explain: _____

5. Have you been involved in the licensing, surveying or certification of a managed care organization, long term care facility, assisted living program, or elder group home in the previous one year? Yes No

   If yes, please explain: _____

6. Have 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, or elder group home in the previous one year? Yes No

If yes, please explain: _____

7. Have you 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: _____

8. Have any of your 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: _____

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

   If yes, please explain: _____

10. Have 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, or elder group homeowner, operator, resident, tenant, or resident/tenant representative in the previous two years? Yes No

    If yes, please explain: _____

11. 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: _____

12. 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: _____

13. Have you provided services to residents of a facility or tenants of an assisted living or elder group home in which a member of your immediate family resides within the previous two years? Yes No

    If yes, please explain: _____

14. Have any of your immediate family members provided services to residents of a facility or tenants of an assisted living or elder group home in which a member of your immediate family resides within the previous two years? Yes No

    If yes, please explain: _____

15. Have you served as a guardian or other surrogate decision-maker for a resident/tenant residing in a facility within the previous one year? Yes No

    If yes, please explain: _____

16. Have any of your immediate family members served as a guardian or other surrogate decision-maker for a resident/tenant located within the previous one year? Yes No

    If yes, please explain: _____

17. Have you resided in a long-term care facility, assisted living or elder group home within the previous two years? Yes No

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

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

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

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

    If yes, please explain: _____

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

    If yes, please explain: _____

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

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

    _____

22. Have you had a founded child or dependent adult abuse report against you since your initial employment with the state? Yes No

    If yes, please provide additional information:

    _____

23. Have you had a criminal conviction against you since your initial employment with the state? 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.*

STATE OF IOWA
Criminal History Record Check Request Form

DCI Account Number: _____
(if applicable)

Mail or Fax completed forms to:

Iowa Division of Criminal Investigation
Support Operations Bureau, 1st Floor
215 E. 7th Street
Des Moines, Iowa 50319
(515) 725-6066
(515) 725-6080 Fax

Send results to:

Name _____

Address _____

_____

Phone _____

Fax _____

I am requesting an Iowa Criminal History Record Check on:

Last Name (mandatory)	**First Name** (mandatory)	**Middle Name** (recommended)
Date of Birth (mandatory)	**Gender** (mandatory)	**Social Security Number** (recommended)
	☐ **Male** ☐ **Female**	

Release Authorization: **Without a signed release from the subject of the request, a complete criminal history record may not be releasable, per Code of Iowa, Chapter 692.2. For complete criminal history record information, as allowed by law, always obtain a signed release from the subject of the request.**

*****This form (DCI-77) is the only approved release authorization form for this purpose.*****

Release Authorization: I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation (DCI). Any criminal history data concerning me that is maintained by the DCI may be released as allowed by law. I understand this can include information concerning completed deferred judgments and arrests without dispositions.

Release Authorization Signature: _____

Iowa Criminal History Record Check Results

(DCI use only)

As of _____, a search of the provided name and date of birth revealed:

☐ No Iowa Criminal History Record found with DCI

☐ Iowa Criminal History Record attached, DCI #_____

DCI initials_____

Release Authorization Information:

Iowa law does ***not*** require a release authorization. However, without a signed release authorization from the subject of the request any arrest over 18 months old, ***without*** a final disposition, cannot be released to a non-law enforcement agency.

Deferred judgments where DCI has received notice of successful completion of probation also cannot be released to non-law enforcement agencies without a signed release authorization from the subject of the request.

If the "No Iowa Criminal History Record found with DCI" box is checked, it could mean that the information on file is not releasable per Iowa law without a signed release authorization.

General Information:

The information requested is based on ***name*** and ***exact date of birth only***. Without fingerprints, a ***positive*** identification cannot be assured. If a person disputes the accuracy of information maintained by the Department, they may challenge the information by writing to the address on the front of this form or personally appearing at DCI headquarters during normal business hours.

The records maintained by the Iowa Department of Public Safety are based upon reports from other criminal justice agencies and therefore, the Department cannot guarantee the completeness of the information provided.

The criminal history record check is of the Iowa Central Repository (DCI) only. The DCI files do not include other states' records, FBI records, or subjects convicted in federal court within Iowa.

In Iowa, a deferred judgment ***is not*** generally considered a conviction once the defendant has been discharged after successfully completing probation. However, it should be noted that a deferred judgment may still be considered as an offense when considering charges for certain specified multiple offense crimes, i.e. second offense OWI. If a disposition reflects that a deferred judgment was given, you may want to inquire of the individual his or her current status.

A deferred sentence ***is*** a conviction. The judge simply withholds implementing a sentence for a certain probationary period. If probation is successful, the sentence is not carried out.

Any questions in reference to Iowa criminal history records can be answered by writing to the address on the front of this form or calling (515) 725-6066 between 8:00 a.m. and 4:00 p.m., Monday - Friday.

REMINDER - (1) Send in a separate Request Form for each last name, (2) a fee is required for each last name submitted, (3) a completed Billing Form must be submitted with all request(s).

Iowa law requires employers to pay the fee for potential employees' record checks.

Iowa Department of Human Services

Authorization for Release of Child and Dependent Adult Abuse Information

This form must be used to authorize release of child or dependent adult abuse information when the person requesting the information does not have independent access to it under Iowa law. Complete a separate form for each person for whom information is requested and email to dhsabuseregistry@dhs.state.ia.us, or fax to (515) 564-4112, or mail to the Iowa Department of Human Services, Central Abuse Registry, P.O. Box 4826, Des Moines, IA 50305.

Please specify which abuse registry you are requesting by checking the appropriate box below:

☐ Child Abuse Registry ☐ Dependent Adult Abuse Registry ☑ Both

Please specify your preferred **method of response** by checking a box and completing the information in Section 1.

☐ Address ☑ Fax ☐ Email

Section 1: ***To be completed by the person or agency requesting the information.***

Requester: Last	First	Agency Name		Telephone Number	
Address				Fax Number	
City		State	Zip Code	Email	

List the name and address of the person whose information is being requested:

Name (last, first, middle)			Birth Date	Social Security Number	
Address	City		County	State	Zip Code

List maiden name, previous married names, and any alias:

What is the purpose of your request for child or dependent adult abuse information?

I have read and understand the legal provisions for handling child and dependent adult abuse information which is printed on the second page of this form.

Signature of Requestor	Date

Section 2: ***To be completed by the person authorizing the Department of Human Services to release their child or dependent adult abuse information.***

I understand that my signature authorizes the requester to receive information to verify whether I am named on the Child Abuse or Dependent Adult Abuse Registry as having abused a child (Iowa Code section 235A.15) or dependent adult (Iowa Code section 235B.6). To the best of my knowledge, the information contained in Section 1 of this form is correct.

Signature of Person Authorizing	Date

Section 3: ***To be completed by the Central Abuse Registry or designee.***

☐ The person whose information is being requested is listed on the Child Abuse Registry as having abused a child.

☐ The person whose information is being requested is not listed on the Child Abuse Registry as having abused a child.

☐ The person whose information is being requested is listed on the Dependent Adult Abuse Registry as having abused a dependent adult.

☐ The person whose information is being requested is not listed on the Dependent Adult Abuse Registry as having abused a dependent adult.

☐ This request for information is denied because the form is incomplete.

Signature of Registry Staff or Designee	Date

Comments

Legal Provisions For Handling
Child and Dependent Adult Abuse Information

Redissemination of Child and Dependent Adult Abuse Information (Iowa Code sections 235A.17 and 235B.8)

A person, agency, or other recipient of child or dependent adult abuse information shall not redisseminate (release) this information, except that redissemination is permitted when **ALL** of the following conditions apply:

- The redissemination is for official purposes in connection with prescribed duties or, in the case of a health practitioner, pursuant to professional responsibilities.
- The person to whom such information would be redisseminated would have independent access to the same information under Iowa Code sections 235A.15 or 235B.6.
- A written record is made of the redissemination, including the name of the recipient and the date and purpose of the redissemination.
- The written record is forwarded to the Central Abuse Registry within 30 days of the redissemination.

Criminal Penalties (Iowa Code sections 235A.21 and 235B.12)

A person is guilty of a criminal offense when the person:

- Willfully requests, obtains, or seeks to obtain child or dependent adult abuse information under false pretenses, or
- Willfully communicates or seeks to communicate child or dependent adult abuse information to any agency or person except in accordance with Iowa Code sections 235A.15, 235A.17, 235B.6, and 235B.8, or
- Is connected with any research authorized pursuant to Iowa Code sections 235A.15 and 235B.6 and willfully falsifies child or dependent adult abuse information or any records relating to child or dependent adult abuse.

Upon conviction for each offense, the person is guilty of a serious misdemeanor punishable by a fine or imprisonment.

Any person who knowingly, but without criminal purposes, communicates or seeks to communicate child or dependent adult abuse information except in accordance with Iowa Code sections 235A.15, 235A.17, 235B.6, and 235B.8 is guilty of a simple misdemeanor punishable, upon conviction for each offense, by a fine or imprisonment.

Any reasonable grounds for belief that a person has violated any provision of Iowa Code Chapters 235A or 235B shall be grounds for the immediate withdrawal of any authorized access that person might otherwise have to child or dependent adult abuse information.

IOWA DEPARTMENT OF PUBLIC SAFETY
SEX OFFENDER REGISTRY

REQUEST FOR REGISTRY INFORMATION

Pursuant to 692A.13, Subsection 3., Code of Iowa, this written request is for information on the person with the following name and one or more of the following identifiers – address, date of birth, or Social Security Number:

Registrant's Last Name First Middle

Registrant's Address Apt.

City State Zip

Date of Birth Social Security Number

Person Requesting Registry Information:

Requester's Last Name First Middle

Requester's Address Apt.

City County State Zip

Signature of Requester

Signature of Agency Official

Date

Agency Date Time

Results of This Request:

☐ Not registered at this date and time.
☐ Registered - Information provided to requester.

DCI-150 8/02/2004 *Dissemination: Original - Sheriff, Copy - Requester*

REQUEST FOR REGISTRY INFORMATION

1. A member of the general public can request registry information.

2. The person requesting the information must provide the following information in writing:

    a. Their own name and address;
    b. Name and address of the person about whom the information is sought.

3. Upon completion of this form, the Sheriff shall release only registry information of the person whose name and address was requested.

4. Dissemination of the Request for Registry Information form:

    a. Original to Sheriff;
    b. Copy to person making request.