

**NORTHEASTERN COLORADO AREA AGENCY ON AGING
HOME DELIVERED DRIVER VOLUNTEER REGISTRATION**

We cannot thank you enough for giving your time to us!!!

NAME: _____

DATE: _____

(Please Print)

ADDRESS: _____

HOME PHONE: _____

CITY/STATE/ZIP: _____

WORK PHONE: _____

BIRTHDATE: ____/____/____ (MM/DD/Year)

SSN (Required): _____

EMERGENCY CONTACT PERSON: _____ PHONE: _____

DAY(s) PREFERRED: (Check all that apply)

____ Once per week ____ More than once a week ____ As a substitute

ON:

____ Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday ____ Any Day

- * I have a car available ____ YES ____ NO
- * Do you have a valid driver's license? ____ YES ____ NO
Driver's License Number _____ State _____
I have auto insurance with _____
- * Do you have any health limitations? ____ YES ____ NO
Please list and describe: _____
- * Do you have a criminal record? ____ YES ____ NO
Please list year and offense: _____
- * Please list states & counties in the states other than Colorado that you have lived in the last two years: _____

HOW DID YOU HEAR ABOUT US: (check all that apply)

____ Newspaper ____ Volunteer/Friend ____ Radio ____ Speaker
____ Church (Name) _____ Other (please list) _____

I understand that the Area Agency on Aging will be doing a Background check according to the State of Colorado requirements.

Area Agency on Aging recipients come from diverse backgrounds. As a volunteer, you agree to serve any recipient assigned on a route regardless of race, creed, origin, or health.

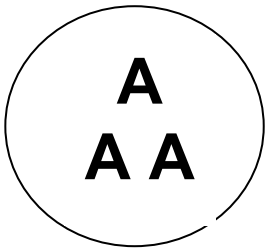
I have read and understand my job responsibilities and agree to them by signing below.

Volunteer Signature

Date

Coordinator Signature

Please list your volunteer experiences here: (Organization, position and year(s) worked):



NORTHEASTERN COLORADO AREA AGENCY ON AGING

VOLUNTEER DISCLAIMER

I, _____ acknowledge that I have read my job responsibilities and fully understand that I will be acting solely as a volunteer for the Area Agency on Aging. As an Area Agency on Aging volunteer, I will not receive any monetary compensation, nor will I represent myself as an employee of the Area Agency on Aging.

I understand and agree that should I be injured, become ill, or otherwise require any form of medical treatment in the course of acting as a Area Agency on Aging volunteer, that I waive any claim against the Area Agency on Aging attributable to such circumstances.

I also understand that the Area Agency on Aging provides meals for homebound persons and that during the course of my volunteer duties, I may learn certain information about the recipient. I understand that this information is strictly confidential and I will not disclose it to any person or entity.

I also understand that all information on this form, pertaining to me, will be kept confidential and used only for Area Agency on Aging purposes.

Volunteer Signature

Date

Area Agency on Aging Representative Signature

Date

BACKGROUND CHECK POLICY (ASU Memo 05-15):

Item G. For employees, volunteers, or contractors providing services, excluding Long-Term Care Ombudsman Services, prior to July 1, 2005, a signed statement by the employee, volunteer, or contractor shall be obtained by the provider agency indicating that the individual has not been convicted of any of the offenses indicated in C.R.S. 27-1-110 (7)(b) and (c).

STATEMENT OF COMPLIANCE

I _____ attest that I have not been convicted of any of the following offenses:
please check if you have NOT been convicted of committing a criminal offense

- ☐ A crime of violence
- ☐ Any felony offense involving unlawful sexual behavior
- ☐ Third degree assault
- ☐ Any misdemeanor offense of domestic violence
- ☐ Violation of a protection order
- ☐ Any misdemeanor offense of child abuse
- ☐ Any misdemeanor offense of sexual assault
- ☐ Any offense of financial exploitation
- ☐ Any alcohol related offenses in the past three (3) years
- ☐ Two (2) or more convictions or chargeable alcohol related accidents in the past two (2) years
- ☐ Two (2) or more drug related convictions or chargeable incidents

If an individual has a conviction on any of the above offenses, the provider will follow-up with the jurisdiction in which the offense occurred per Item C of the Background Check Policy (ASU Memo 05-15).

Signature

Date