



310 Old Corvallis Road  
Hamilton Montana 59840  
406-363-5690  
www.ravallicca.org

## Volunteer Application

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle initial:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
**Street Apt# City State Zip**

**Telephone Numbers:** \_\_\_\_\_ **Email** \_\_\_\_\_  
**Home/Cell**

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Driver's License Number:** \_\_\_\_\_

**How did you hear about Ravalli County Council on Aging?**

**I am available to volunteer:**

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

**Please check the box that you would like to volunteer for.**

- Meals on Wheels Delivery Driver
- Telephone Reassurance
- Commodities
- Senior Medicare Patrol

- Visit with Seniors in Nursing Home or Assisted Living – Friendly Visitor
- Happy Helper
- Yard Work
- Grocery Shopping
- Computer assistance /Training
- Office / Clerical assistance

- The above-described work will be noncompensable. Except as otherwise provided. I understand this will not confer on the status of a RCCOA employee.
- I understand that if I do any business for the RCCOA that involves driving my own vehicle. I must provide a valid Montana driver’s license and proof of vehicle liability insurance.
- I understand that either the RCCOA or I may cancel this agreement at any time by notifying the other party. I hereby volunteer my services as described above to assist the RCCOA in its mission.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Volunteers are America's silent strength. Those who give of themselves in a spirit of unselfish devotion to the needs of others are truly this nation's most generous, unsung heroes." - William Ward***

Volunteer Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Copy of Auto Insurance Company Received: Yes \_\_\_\_\_ No \_\_\_\_\_

Signature of RCCOA Staff: \_\_\_\_\_

**Person to Notify in Case of Emergency**

Name	
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Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	



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## CONFIDENTIALITY AGREEMENT

Ravalli County Council on Aging recognizes the importance of protecting confidential information concerning clients, care givers, volunteers and coworkers. It is the obligation of every employee, student/work study, and volunteer staff member to maintain this confidentiality.

Within the Agency, paid and non-paid staff will not discuss or otherwise divulge any information concerning any client, customer or fellow staff member of Ravalli County Council on Aging except on a need-to-know basis for the benefit of the client, customer, or fellow staff member.

Outside the Agency, unless authorized by management, paid or non-paid staff may not provide proprietary information to any outside organization or individual.

Care should be taken at all times to see that case folders and other confidential information are secure and not accessible to others who may be in the office.

I have read and agree to adhere to the conditions of this confidentiality agreement. I also acknowledge that any breach of confidentiality may result in disciplinary action up to and including termination.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: (Please print) \_\_\_\_\_



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## Background Check Authorization/General Release

I \_\_\_\_\_ hereby authorize Ravalli County Council on Aging to request and receive any Montana Criminal History records on file for me and run a search on the Department of Justice's National Sex Offender Public Registry. I further authorize Ravalli County Council on Aging to verify any past or present Employment History I have provided.

I release and discharge Ravalli County Council on Aging and all of their Employees from any and all claims and liability arising out of any request(s) for, or receipt of, information or records pursuant to this authorization and understand that any reports may contain information about my character, general reputation, personal characteristics, and mode of living, whichever are applicable.

I understand placement into a volunteer program is contingent upon Ravalli County Council on Aging's review of my criminal history, if any, and that results of the search will be shared within the program, as appropriate. I understand I will be given an opportunity to review and challenge the factual accuracy of a result before action is taken to exclude me from placement. I

understand I will not be permitted to serve vulnerable beneficiaries during this review period but will be allowed to participate in training activities. I acknowledge that I have voluntarily provided the below information for consideration into a volunteer program of Ravalli County Council on Aging, and I have carefully read, and I understand this authorization.

If consent is not given for the background checks, I understand I will not be considered for a position in the program(s).

Name (print): \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Previous (former) Names: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Government Issued Photo ID #: \_\_\_\_\_

State Issued: \_\_\_\_\_ Expiration: \_\_\_\_\_



***Ravalli County Council on Aging Use Only:***

Volunteer information verified by: \_\_\_\_\_