



Thank you for your interest in the MAP Volunteer Program.

Enclosed is a job description, application, and volunteer assurance about this special opportunity.

Once your application has been processed, I will be in touch with you to go over any questions you may have and discuss possible training dates and times.

If you have any questions, please contact MAP at 1-800-763-2828.

Please return your completed application to:

Oklahoma Insurance Department

3625 NW 56th Suite 100

Oklahoma City, OK 73112

Or Fax: 405-522-4492

We look forward to hearing from you soon!

MAP VOLUNTEER APPLICATION

Applicant Name: _____

Date of Birth: _____

Date: _____

Contact Information:

Mailing Address:

Street: _____

City: _____ State: _____

Zip: _____ Home Phone: (____) _____

Cell Phone: (____) _____

E-Mail Address: _____

Emergency Contact:

Name: _____

Relationship: _____ Home Phone: (____) _____

Other Phone: _____

I. Volunteer Talents

A. Which of the following volunteer positions interest you?

- Counselor— Provides information about Medicare and related programs to beneficiaries and their families, making sure they have the necessary details to make educated decisions about their individual needs.
- Administrative Volunteer— Provide administrative support including data entry and other clerical duties.
- Outreach Assistant—Educates the community about the program and Medicare related topics.

B. Why are you interested in volunteering for MAP?

C. Are you fluent in any language other than English (including sign language)?

- Yes (Please list which language): _____
- No

D. Skills and Interest (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Computer/Internet | <input type="checkbox"/> Public speaking with small groups |
| <input type="checkbox"/> Public speaking with large groups | <input type="checkbox"/> Organize/Scheduling |
| <input type="checkbox"/> Teaching/Training | <input type="checkbox"/> Assist individuals/direct client service |
| <input type="checkbox"/> Data Entry | <input type="checkbox"/> Help with Events/Booths |
| <input type="checkbox"/> General Office Work | |
| <input type="checkbox"/> Other: _____ | |

E. Availability

Hours per month: 4 or less 5 to 10 More than 10

Preferred days and times:

- Monday Morning Afternoon Wednesday Morning Afternoon
- Tuesday Morning Afternoon Thursday Morning Afternoon
- Wednesday Morning Afternoon Friday Morning Afternoon
- As Needed

F. Do you have a current driver's license and have reliable transportation?

Yes No

II.

A. Employer Information (include paid and volunteer experience)

Retired Yes No

1. Company/Organization: _____

Dates of Service From: _____ To: _____

Contact Person: _____

Phone: () _____ Paid Employee Volunteer

2. Company/Organization: _____

Dates of Service From: _____ To: _____

Contact Person: _____

Phone: () _____ Paid Employee Volunteer

B. Education

College/Trade/Vocational: _____

Degree (if applicable): _____

C. Optional

Do you have any medical conditions you would like us to be aware of?

Yes No If yes, please describe: _____

III. Please list two references that are not related to you.

1. Name: _____ Relationship: _____

Phone: _____ How long known: _____

2. Name: _____ Relationship: _____

Phone: _____ How long known: _____

IV. Screening Questions

A. Are you currently employed at any of the following? Please check if applicable.

- Insurance company, agent, or broker
- Financial planning service
- Health insurance claims or billing service
- Law firm or legal service organization
- Other: _____

B. If you answered yes to any of the above, please explain:

V. Declaration

I declare that the information provided and statements made in this application are true and complete to the best of my knowledge and belief. I also declare that I understand that the purpose of the training I receive as a volunteer is to provide services free of charge to Medicare beneficiaries and is not to be used for my personal monetary gain.

Signature: _____ Date: _____

MAP Volunteer Program

As a volunteer for MAP, I agree to act within the scope of my responsibilities and abide by all program policies and procedures as specified in, but not limited to, the following: Volunteer job descriptions, handbooks, manuals, and other guidance. MAP is not responsible for any activity that I engage in or any responsibility that I assume other than those specified in the above mentioned program policies and procedure. Any actions that I take outside the scope of responsibility for my volunteer position will be taken at my own personal risk.

Nature of Volunteer Service:

- I understand that as a volunteer, I will be relied upon to serve Medicare beneficiaries and their community. The scope of responsibilities varies for each volunteer.
- I understand that my responsibilities may include providing accurate and objective counseling assistance to Medicare beneficiaries, their representatives and caregivers, or persons soon to be eligible for Medicare.
- I understand that my responsibilities may also include the use of internet-based programs to help clients compare health and prescription drug plan options.
- I understand that my responsibilities may also include educating the public on Medicare, Medicaid, and health insurance issues that affect older Americans and people with disabilities.
- I understand that my volunteer activities may need to take place at specific counseling sites, and also by telephone.
- I understand that I must submit monthly documentation of my activities to my volunteer coordinator.
- I understand that volunteers provide services free of charge to any Medicare beneficiary who seeks assistance from the program.

Confidentiality:

- I understand that I will have access to sensitive information about my clients, including medical, insurance, financial, and other confidential personal data.
- I agree to keep such information confidential and to use it only to perform my duties as a SHIP/SMP volunteer, to the extent that a client explicitly authorizes.

Non-Conflict of Interest:

MAP volunteers cannot promote private or personal interests as they go about performing the duties described in the volunteer program policies and guidelines. To comply with this requirement, I agree to the following.

- I will in no way attempt to conduct market research, or solicit or persuade clients to purchase or enroll in a specific type of health insurance coverage, to switch from one carrier to another to replace existing insurance coverage, to go to a specific provider of service for treatment, or to direct a client to a specific agent/broker, or to any profit-based billing service.

- I will not disclose or use confidential or other personal information obtained from a client through my association with MAP for personal gain or the gain of my employer or any other party.

Agreement:

- I understand that as a volunteer, I am committing to hours each month.
- I agree to attend initial and update training program as required.
- I agree to respect the confidentiality of my clients and to exercise good faith and integrity in performing my duties as a MAP volunteer.
- I agree to complete a background check.
- I understand that a breach of this agreement will result in the termination of my volunteer service and may be subject me to liability for harm that I cause to a client through a breach of confidentiality or acting outside the scope of my responsibilities.

Volunteer Signature: _____

Date: _____



LOCAL HELP FOR PEOPLE WITH MEDICARE

