FCHCC LONG-TERM CARE OMBUDSMAN APPLICATION

Franklin County Home Care is committed to diversity in employment practices and service delivery. Our Agency prohibits discrimination and takes affirmative action to serve people in our community with fairness and respect for all. We recognize that many differences among people may be barriers to inclusion. These differences include race, sex, age, disability, nationality and ancestry, class, religious and political beliefs, marital status, sexual orientation, and gender identity. We welcome and value all persons, and we dedicate our Agency to an ongoing effort to achieve the goal of greater diversity among our employees, clients and others whom we serve.

Name _____ Date of Application _____
Last First Middle

Address_____
Number Street City State Zip Code

Telephone _____ Email _____

Social Security Number _____

Emergency Contact _____ E. Contact Tel # _____

GENERAL INFORMATION

1. Why are you interested in becoming an Ombudsman?

2. What relevant activities have you been involved with in the past?

3. Are you fluent in a language other than English?

4. Are you able to:

a. commit yourself to 18 hours of initial training? ____Yes ____ No

b. visit residents in one long-term care facility every week? ____Yes ____ No

c. attend a monthly meeting locally with the program director? ____Yes ____ No

VOLUNTEER ACTIVITY

Organization _____ Position _____

Dates of Service _____

Organization _____ Position _____

Dates of Service _____

REFERENCES

1. Name _____
Last First Middle

Address_____
Number Street City State Zip Code

Telephone _____ Email _____

2. Name _____
Last First Middle

Address_____
Number Street City State Zip Code

Telephone _____ Email _____

3. Name _____
Last First Middle

Address_____
Number Street City State Zip Code

Telephone _____ Email _____

DISCLOSURE OF POTENTIAL CONFLICT OF INTEREST

1. Have you or any immediate family member ever been employed at a long term care facility?
____Yes ____ No
If yes, please list the facility(s) and describe your participation.

2. Do you or any immediate family member hold any type of financial interest in a long term care facility?
____Yes ____ No
If yes, please list the facility(s) and type of financial interest.

3. Do you or any immediate family members have a controlling interest in a long term care facility(s), i.e. Board of Directors, etc.?
____Yes ____ No
If yes, please list the facility(s) and describe your participation.

4. Have you or any immediate family member been a resident (past or present) of a long term care facility?
____Yes ____ No
If yes, please list the facility(s).

5. Do you have employment or financial considerations that might interfere or be construed to conflict with your duties to residents of a long term care facility, i.e. a lawyer dealing with elder issues or a salesman selling items that are used by residents of long term care facilities?
____Yes ____ No
If yes, what is your occupation or financial interest?

6. Is there any other additional information that you feel is important for the Long Term Care Ombudsman Program to know?
____Yes ____ No

STATEMENT OF UNDERSTANDING

I understand that the Massachusetts State Long Term Care Ombudsman has the authority to decertify my position as an Ombudsman Representative at any time if I do not meet the qualifications, guidelines or expectations as stated in the Older Americans Act, Massachusetts Statutes, and Massachusetts Long Term Care Ombudsman policies, procedures and guidelines.

_____ _____

Signature of Applicant Date

AGREEMENT

I certify that the information on this application is true, complete, and correct. I hereby authorize the investigation of my past activities and I release from all liability all persons, companies, and corporations supplying such information. I understand that false answers, statements, or significant omissions made by me on this form shall be sufficient cause for denial of volunteer opportunity or discharge.

_____ _____

Signature of Applicant Date