# PROTECTIVE MONEY MANAGEMENT PROGRAM (PMMP)
# VOLUNTEER APPLICATION CHECKLIST

Please use this form as a guide when completing your application materials.

Please return this with your application materials.

Applicant Name (please print) _____

*First* *Middle* *Last*

Birth Date

Include the following documents in your application:

- ☐ PMMP Volunteer Application Checklist
- ☐ PMMP Volunteer Application
- ☐ RRCS Confidentiality Agreement
- ☐ PMMP Conflict of Interest Form
- ☐ PMMP Volunteer/Program Coordinator Form
- ☐ DMV Information Request Form
- ☐ Virginia Department of Social Services/Child Protective Services Central Registry Release of Information Form (DO NOT SIGN. THIS FORM MUST BE NOTARIZED. WE CAN NOTARIZE THE FORM AT RRCS).

Return all application materials, and address any questions, to:

| | |
|---|---|
| Return To: | Lola Walker |
| Local Sponsoring Agent | Rappahannock Rapidan Community Services (RRCS) |
| Mailing Address | PO Box 1657<br>Culpeper, VA 22701 |
| Phone Number | 540-825-3100, extension 3358 |

**OFFICE USE ONLY**

- ☐ Received
- ☐ Interviewed
- ☐ Trained
- ☐ Agreements
- ☐ Matched
- ☐ Other

# PROTECTIVE MONEY MANAGEMENT PROGRAM (PMMP)
# VOLUNTEER APPLICATION

## PERSONAL

NAME: _____
*(first)* *(middle)* *(last)*

ADDRESS: _____
*(street)*

VA
*(county)* *(city/town)* *(state)* *(zip)*

PHONE: _____
*(home)* *(office)* *(cell)*

E-MAIL: _____

Profession/Type of Work Experience:

Are You Currently Employed? Full-time ☐ Part-time ☐ Retired ☐ Seeking Employment ☐

Current Employer Name: _____

Current Employer Address _____

Current Employer Phone: _____

How did you hear of this program?

What interestă you about being a money management volunteer?

## EDUCATION/INTERESTS

What is the highest level of education you have attained?

High School ☐ College/Other Post High School Education ☐ Advanced Degree ☐

Are you familiar with: Online Banking ☐ Online Bill Pay ☐

Do you have a client preference? (Check all that apply) No Preference ■ Male ☐ Female ☐

Elderly ☐ Individual in Group Care ☐ Individual with Drug/Alcohol Problem ☐ Homeless ☐

Handicapped: Mentally ☐ Physically ☐ Homebound ☐

Do you speak any foreign languages? If yes, please specify: _____

When would you prefer to visit clients? Weekdays ☐ Weekends ☐ Evenings ☐

# PROTECTIVE MONEY MANAGEMENT PROGRAM (PMMP)
# VOLUNTEER APPLICATION

Have you ever been convicted of a crime or denied bond? Yes ☐ No ■

In addition to, or instead of becoming a representative payee or bill payer volunteer, would you be willing to provide help in one or more areas listed below? Yes ■ (check all that apply) No ☐

- ☐ Provide temporary help to a volunteer who is on leave or vacation
- ☐ Provide general office assistance (Office Aide Position).
- ☐ Assist with volunteer recruitment in your area.
- ☐ Monitor bill payer's work with client accounts (Monitor Position).

In case of emergency, please contact:

Name: _____

Phone: _____

## LOCAL REFERENCES

Please list the names and addresses of two references (not related), one of which is a professional contact (employer, teacher, minister, etc.). Full addresses and phone numbers are necessary.

Name: _____

Address: _____

Phone: _____ (Home) _____ (Work) _____ (Cell)

Name: _____

Address: _____

Phone: _____ (Home) _____ (Work) _____ (Cell)

Volunteers are asked to make a renewable one-year commitment to this job. Except for unexpected developments, are you willing and able to commit to the full one-year term for the program?

Yes ■ No ☐

Please use the reverse of the form if you wish to include any other information in this application.

**I certify that the information given herein is accurate to the best of my knowledge. I understand that the references listed above will be contacted and that the sponsoring agency will do a records check on qualified applications. I consent to the release of all relevant information concerning my ability and fitness to work as a Protective Money Management Program Volunteer. I understand that this information will be held in confidence and not released to any outside person or agency for any purpose other than to verify information.**

Signature: _____

Date: _____

PMMP Staff Signature: _____

# Rappahannock-Rapidan Community Services

# Confidentiality Agreement

Rappahannock-Rapidan Community Services adheres to the strictest standards of information pertaining to its employees and to any individual receiving services. Further, the agency is bound by federal and state regulations regarding consumer confidentiality. These regulations include the authority of the Department of Health and Human Services, Office of the Secretary, 45 CFR Parts 160, 164 and 142; Federal Law 42 CFR Part 2, Title 37.1-84.1, Code of Virginia, and 12 VAC 35-115-80.

All Rappahannock-Rapidan Community Services' site reviewers, contractors, vendors, employees, volunteers, trainees, or students are ethically and legally bound to maintain the confidentiality of consumers or other recipients of services.

The only exceptions include:

1) proper authority to do so at the written request of the consumer or recipient;
2) court order via subpoena or as provided for by federal confidentiality of alcohol or drug abuse consumer records;
3) a situation where life or death medical emergencies prompt one's best judgment to take immediate action; or
4) as required by law.

Access to and release of protected health information is limited to the minimum necessary required to fulfill position responsibilities under policy titled "Minimum Necessary Use of Protected Health Information in Agency Operations."

Confidentiality regulations shall in no way hinder employees from reporting suspected abuse of children or adults.

***I have received copies and instruction of privacy and security policies related to my position. I have read the above Sections of this Agreement and I understand them. I agree to comply with the policies. I understand that a violation of this policy may result in disciplinary action, up to and including termination, as well as civil or criminal liability.***

| _____ | _____ | _____ |
|---|---|---|
| Signature | Printed Name | Date |

| _____ | _____ | _____ |
|---|---|---|
| Position Title or Name of Organization | Employee Number | PHI Access Code |

# CONFLICT OF INTEREST AGREEMENT

In accordance with the spirit of service and assistance to those needing help to manage their money through the AARP Money Management Program (MMP), all MMP volunteers who are part of this program are required to sign this Conflict of Interest Agreement.

I _____, (Representative Payee or Bill Payer Volunteer) agree to:

1. treat with strict confidentiality any information concerning a client with whom I am working as a Representative Payee or Bill Payer Volunteer, discussing client issues only with appropriate program staff

2. never use my knowledge of a client's personal financial situation for my own benefit or financial gain or that of my employer, associates, family, friends or acquaintances

3. never require the payment of any money or property, regardless of its nature, in exchange for providing MMP services

4. never accept loans or gifts of money or property from a client, except non-cash personal gifts, the value of which shall not exceed $25 in any calendar year

5. make no loans or gifts of money or property to a client, except personal gifts, the value of which shall not exceed $100 in any calendar year

6. make no suggestions or recommendations to any client from which I, my employer, associates, family, friends or acquaintances may profit or benefit in any way

7. refrain from giving a client any advice on matters of health care or real property

8. avoid any activity which would place me in a position of actual conflict of interest or the appearance of conflict of interest

9. never use a client's ATM card, debit card, check card or any similar card

10. never accept Power of Attorney from my client without written permission from AARP and the sponsoring agency.

I also agree that the requirements and prohibitions of this Conflict of Interest Agreement shall survive the expiration of my service and tenure as a Representative Payee or Bill Payer Volunteer. Failure to abide by any terms of this agreement is grounds for immediate dismissal. Please sign, date, and return to your local Program Coordinator.

Accepted and agreed to

by Volunteer: _____ Date: _____

Coordinator: _____ Date: _____

3/1/06

# Protective Money Management Program (PMMP)
# Volunteer/Program Coordinator Agreement

As partners in the Protective Money Management Program (PMMP), volunteers and the Program Coordinator have rights and responsibilities to make the program a success.

***THE VOLUNTEER***

As a volunteer in the Protective Money Management Program, I agree to work under the supervision of the Program Coordinator and other agency administrative staff, and to carry out my assigned duties diligently and responsibly.

- I will attend scheduled orientation/training sessions and in-service meetings.
- I will maintain confidentiality concerning circumstances of my assigned clients, discussing their circumstances only with program staff, and will otherwise abide by the volunteer guidelines and code as outlined.
- I will not enter into any financial or business relationship with my assigned clients during the term of my volunteer service or thereafter.
- I will maintain accurate records regarding my activities on behalf of my assigned representative payee clients so that I can provide an accurate accounting of how benefits are used *or* I will submit monthly client visitation reports regarding my activities and my activities with my assigned bill payer clients to the program offices and will submit an initial and updated list of client income and expenses, if necessary.
- I understand that I will be responsible for all expenses entailed in such service, including use of my car when used for home visits to clients, unless my sponsoring agency reimburses for mileage.
- It is understood that my term of volunteer service will be for one year, renewable by mutual consent, and that I will inform the agency at least 30 days in advance when I will be away from town and unable to maintain my monthly contacts with the program clients, or give 60 days notice when I plan to terminate my volunteer activity.
- I agree to cease immediately my role managing the client's money and shall cooperate in transferring financial information to either the sponsor or new volunteer if directed to do so by the client, AARP Foundation, state, or local agency.
- I understand that AARP Foundation provides limited protection for client funds for my handling of funds in the designated account.

# Protective Money Management Program (PMMP)
# Volunteer/Program Coordinator Agreement

***THE PROGRAM COORDINATOR***

I assume the responsibility to ensure that volunteers have the support needed to do their work. I recognize and agree to the following terms:

- I will respect the volunteer's contribution of time and skills by providing meaningful work assignments and by giving serious attention to any problem cases which the volunteer identifies.
- I will provide the manual, initial and ongoing training to the volunteer.
- I will provide assistance and supervision to the volunteer by maintaining regular communication through in-person contact, periodic meetings, phone calls, and letters.
- I will be available to answer questions and assist with resolutions of specific cases.
- I will respect the schedule of the volunteers and will be available during the times we have arranged. If I need to change the schedule, I will contact the volunteer involved.
- I will provide the materials necessary to do the job, including forms, supplies, and space.
- I will encourage volunteers to offer suggestions for improving the program.

Volunteer Name (print): _____

Volunteer Signature: _____ Date: _____

Program Coordinator Signature: _____ Date: _____

**VA Department of Social Services**
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

**Central Registry Release of Information Form**

## Search Fee $10.00

**Purpose of Search, Check one**: ☐ Adam Walsh Law ☐ Adoptive Parent ☐ Babysitter/Family Day Care ☐ CASA ☐ Children's Residential Facility ☐ Custody Evaluation ☐ Day Care Center ☐ Foster Parent ☐ Institutional Employee ☐ Other Employment ☐ School Personnel ☐ Volunteer ☒ Other

**MAIL SEARCH RESULTS TO: Agency, Individual or Authorized Agent Requesting Search**

| | |
|---|---|
| **Name** | Rappahannock Rapidan Community Services |
| **Address** | PO Box 1568 |
| **City** | Culpeper **State** VA **Zip** 22701 |
| **Contact Name** | Robin W. Woodard **Tel.#** 540-825-3100 **Ext** 3233 |
| **Contact E-Mail** | rwoodard@rrcsb.org |

**Payment/FIPS Code**
**(Use only if assigned by OBI-CRU)**

**Mandatory if agency code has been assigned**

**PART I: DETAILS OF INDIVIDUAL WHOSE NAME MUST BE SEARCHED**

| Last Name | First Name | Full Middle Name – (given at birth) - **No initials** (if middle name is an initial, indicate "Initial Only") |
|---|---|---|
| | | |

| Maiden Name (last name before marriage) | Sex | Date of Birth **(MM/DD/YYYY)** | Race |
|---|---|---|---|
| | ☐ Male ☐ Female | | |

| Driver's License Number or ID # | Social Security Number | Other names used; nicknames, legal names (refer to instruction page) |
|---|---|---|
| | | |

| Current Address (Include Street # and Apt #) | City | State | Zip |
|---|---|---|---|
| | | | |

**Applicant's Prior Addresses**

| Include Street # and Apt # | City | State | Zip | Start Date **(MM/YY)** | End Date **(MM/YY)** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

If married, list current spouse. If previously married, list all previous spouses. If you have never been married, write 'N/A'.

| Last Name | First Name | Full Middle Name (given at birth) | Maiden Name | Race | Sex | Date of Birth **(MM/DD/YYYY)** |
|---|---|---|---|---|---|---|
| | | | | | ☐ Male ☐ Female | |
| | | | | | ☐ Male ☐ Female | |
| | | | | | ☐ Male ☐ Female | |

**List all of your children.** If you have none, write **'N/A'.** Include all adult children, step and foster children not living with you.

| Last Name | First Name | Full Middle Name (given at birth) | Relationship | Sex | Date of Birth **(MM/DD/YYYY)** |
|---|---|---|---|---|---|
| | | | | ☐ Male ☐ Female | |
| | | | | ☐ Male ☐ Female | |
| | | | | ☐ Male ☐ Female | |

**VA Department of Social Services**
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

**Central Registry Release of Information Form**

**Search Fee $10.00**

## PART II: CERTIFICATION AND CONSENT FOR RELEASE OF INFORMATION

I hereby certify that the information contained on this form is true, correct and complete to the best of my knowledge. Pursuant to Section 2.2-3806 of the *Code of Virginia*, I authorize the release of personal information regarding me which has been maintained by either the Virginia Department of Social Services or any local department of social services which is related to any disposition of founded child abuse/neglect in which I am identified as responsible for such abuse/neglect. I have provided proof of my identity to the Notary Public prior to signing this in his/her presence.

_____ _____

Signature of person whose name is being searched (Sign in presence of Notary)

Parent or Guardian signature required for minor children under the age of 18

## PART III: CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL

City/County of _____

Commonwealth/State of _____

Acknowledged before me this _____ day of _____, year_____

_____ _____

**Notary Public Signature** **Notary Number**

My Commission Expires: _____ Notary Seal

## PART IV: CENTRAL REGISTRY FINDINGS – COMPLETED BY CENTRAL REGISTRY STAFF ONLY

1. We are unable to determine at this time if the individual for whom a search has been requested is listed in the Central Registry. Please answer the following questions and return to the Central Registry Unit in order for us to make a determination:

_____
_____
_____
_____
_____

Worker: _____ Date: _____

2. _____ Based on information provided by the Local Department of Social Services, we have determined that _____ is listed in the Child Abuse/Neglect Central Registry with a founded disposition of child abuse/neglect. For more detailed information, contact the

_____ Dept. of Social Services in reference to referral _____ phone#_____

_____ Dept. of Social Services in reference to referral _____ phone#_____

3. _____ As of this date, based on the information provided, the individual whose name was being searched is **NOT** identified in the Central Registry of Child Abuse/Neglect.

Signature of worker completing search: _____ Date: _____

OBI Staff Only