OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Volunteer Application Introduction

SHIBA MISSION STATEMENT

The Statewide Health Insurance Benefits Advisors (SHIBA) provides free, unbiased information about health care coverage and access to help improve the lives of all Washington state residents. We cultivate community commitment through partnership, service, and volunteering.

Thank you for your interest in becoming a SHIBA volunteer! Statewide SHIBA volunteers assist in many ways to help Medicare-eligible clients make informed decisions about their own health care.

Volunteer Roles

There are many volunteer roles available to match the diverse skills, abilities and personal goals of prospective volunteers. Appropriate duties and guidance are established based on one-on-one discussions between the Volunteer Coordinator and the prospective volunteer. SHIBA will provide training appropriate to the role(s) assigned. Some typical roles to consider are; available roles will be discussed during the in-person interview.

- Administrative, data entry, clerical and technical support
- Community Outreach (education/public speaking)
- Senior Medicare Patrol (SMP) volunteer
- Counselor
- Special projects

Screening Process

All prospective volunteers will complete a Washington State Patrol (WSP) Request for Criminal History Information form and receive a background check in accordance with RCW 43.43.830 through 43.43.845. SHIBA will not conduct background checks or process applications until prospective volunteers have been in contact with the Volunteer Coordinator from their local SHIBA sponsor.

PLEASE COMPLETE THE FOLLOWING FORMS:

❍ Volunteer Application
❍ Volunteer Agreement
❍ SHIBA Online Resource Record
❍ Washington State Patrol Background
❍ Confidentiality Agreement

SUBMIT ALL COMPLETED FORMS TO SOUND GENERATIONS (King County Sponsor Site)

1) **Email** completed forms as .pdf document(s) to: shibaadmin@soundgenerations.org

OR Mail to:

2) **Location** Sound Generations
ATTN: SHIBA Program
2208 2nd Ave, Suite 100
Seattle, WA 98121

3) **Fax to:** (206) 448-5748 Attn: SHIBA Program

OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Volunteer Application

SHIBA provides equal opportunities without regard to race, creed, color, religion, national origin, gender, sexual orientation, gender identity/expression, age familial status, marital status, physical or mental disability, or veteran's status. **Minors under age 18** may volunteer for SHIBA with parent/guardian consent.

PLEASE WRITE LEGIBLY – USE INK	**DATE**(MM/DD/YY): / /

Personal Information

Name:		
City:	**County:**	**Zip:**
Home Phone: ( )	**Work Phone: ( )**	
Cell Phone: ( )	**Email:**	

Availability – Check the days, note times you are available to volunteer

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Mornings						N/A	N/A
Afternoons						N/A	N/A
Evenings	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Employment

Employer (Current or former – PLEASE CIRCLE ONE):

Supervisor Name:	**Supervisor Phone No: ( )**

Position(s)held:

Education

❍ **High school**	❍ **College**
❍ **Current student**	❍ **Graduate school**

Current students:

Is your volunteer work related to a school project or requirement ❍ **Yes** ❍ **No**

If yes, please describe:

OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Volunteer Application

Why do you want to volunteer for SHIBA?	
Interests	
Please tell us which areas you are interested in volunteering	
❍ Data entry	❍ Phone/reception
❍ Special events	❍ Community outreach
❍ Counseling people with Medicare	❍ Community outreach set up/clean up
❍ Counseling people(non-Medicare)	❍ Volunteer coordination/recruitment
❍ Public speaking	❍ Administrative/clerical
❍ Senior Fraud and Abuse - Senior Medicare Patrol (SMP)	
❍ Other	
Special Skills or Qualifications	
Summarize special skills and qualifications acquired from employment, volunteer work, or through	
activities including hobbies sports etc.	
Previous Volunteer Experience	
Summarize previous volunteer experience.	
Reference Checks	
Name:	Phone: ( )
Relationship:	Length of Time Known:
Name:	Phone: ( )
Relationship:	Length of Time Known:
Name:	Phone: ( )
Relationship:	Length of Time Known:

OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Volunteer Application

Background Check
Your volunteer capacity with SHIBA may involve unsupervised access to vulnerable adults and/or developmentally disabled people. Therefore, as required by Washington state statute (RCW 43.43.834), we need to collect the following information: **Have you ever been convicted of a crime?** ❍ **Yes** ❍ **No**
Has any finding been made against you in any civil adjudicative proceeding of domestic violence, abuse, sexual abuse, neglect, or financial exploitation of a child, vulnerable adult or developmentally disabled person? ❍ **Yes** ❍ **No**
Civil adjudication proceeding includes judicial or administrative orders that become final due to the failure of the alleged perpetrator to timely exercise a right afforded to him/her to administratively challenge findings made by the Department of Social and Health Services or the Department of Health. **If the answer to either of the above questions is yes, please provide the details of:** • **Conviction or decision** • **Date of conviction or decision** • **State court, board, or department in which you were convicted or any decision made**

OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Volunteer Application

NON-AFFILIATION – CONFLICT OF INTEREST STATEMENT

Statewide Health Insurance Benefits Advisors (SHIBA) provides health insurance information via volunteers who are not professionals in the field but are trained by the Washington State Office of the Insurance Commissioner.

NONAFFILIATION – CONFLICT OF INTEREST: I do not have an active insurance license. I will act in good faith without selling, recommending, or endorsing any specific insurance product, agency, or related service. Nor am I currently affiliated with or employed by a health insurance company, agency or service, nor am I in a position to sell or receive commissions from health insurance products or services, or use my SHIBA affiliation for purposes of personal financial gain.

By submitting this application, I affirm the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

I, the undersigned, understand that all statements I make in response to this inquiry are subject to investigation and verification prior to appointment. I further understand the SHIBA program may make an inquiry to the Washington State Patrol to verify any record for convictions of offenses, adjudications or abuse in a civil action, or disciplinary board final decision. I do hereby certify, under penalty of perjury, that my responses to this inquiry are true and correct to the best of my knowledge, in accordance with RCW 43.43.834.

Name (please print):	
Signature:	**Date (mm/dd/yy): / /**

If under age 18 -

Parent/Legal Guardian (please print):	
Signature:	**Date (mm/dd/yy): / /**

OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Volunteer Agreement

The purpose of this agreement is to ensure a common understanding between the Sponsor organization, the Washington State Office of the Insurance Commissioner (OIC), the Statewide Health Insurance Benefits Advisors (SHIBA) and the Volunteer.

Volunteer Name: First, MI, Last (please print legibly):

SHIBA Sponsoring Organization Name **County**

I agree to the following:

I understand SHIBA is a consumer education, assistance and advocacy service of the Office of the Insurance Commissioner (OIC) and the sponsoring agency, not a policy creating or lobbying organization.

1. ***NONAFFILIATION – CONFLICT OF INTEREST***
   I do not have an active insurance license. I will act in good faith without selling, recommending or endorsing any specific insurance product, agency, or related service. Nor am I currently affiliated with or employed by a health insurance company, agency or service, nor am I in a position to sell or receive commissions from health insurance products or services, or use my SHIBA affiliation for purposes of personal financial gain.

2. ***IMPARTIALITY***
   If in the future I become affiliated with an insurance company, agency or service, or I'm in a position to use my SHIBA affiliation for personal financial gain, I will terminate my position with SHIBA. Also, I will remain impartial, refraining from advising or expressing my opinions regarding a consumer's course of action.

3. ***CONFIDENTIALITY***
   I will not disclose any identifying client personal information to anyone outside the SHIBA organization without the client's authorization in accordance with state and federal law.

4. ***NON DISCRIMINATION***

I understand the act of favoritism or making a difference in treatment based on an individual's race, creed, color, religion, gender, national origin, age, sexual orientation, gender identity, expression, familial status, marital status, physical or mental disability, political party, or veteran's status is not permitted.

5. ***LOBBYING***

I agree that I will not use public resources for political campaigns, to support or oppose candidates, ballot issues, or political causes. No one may use or authorize the use of facilities of an agency, directly or indirectly, for the purpose of assisting a campaign for election of a person to an office or for the promotion of or opposition to a ballot proposition. I understand that I may be asked to provide information that identifies the effects of current or future legislation to OIC staff for their information. Resources include, but are not limited to, stationary, postage, machines, equipment, state employees or volunteers during working hours, vehicles, office space, publications of the agency, and clientele lists of persons served by the SHIBA or the OIC.

I understand that I may be asked by staff to provide information that identifies the effects of current or future legislation, regulation, or program changes to OIC staff to support advocacy and consumer protection efforts.

Volunteer (print name)	**Volunteer Coordinator (print name)**
Signature	**Signature**
Date	**Date**

All prospective volunteers will complete a Washington State Patrol (WSP) Request for Criminal History Information form and receive a background check in accordance with RCW 43.43.830 through 43.43.845.

If you have already competed the check, please include a copy of the report with the application **OR** sign and date below to confirm that you have completed the check and have a copy on file.

Date	**Volunteer Coordinator Signature**

OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

SHIBA Online Resource Record

PLEASE WRITE LEGIBLY – USE INK	****Completed by SHIBA program staff only****
	NPR No:
	Background check completed (MM/DD/YY):

Personal Information (Completed by volunteer)

Name:	
Mailing Address:	
City: **Zip:**	**County:**
Home Phone: ( )	**Work Phone: ( )**
Cell Phone: ( )	**Email:**

Emergency Contacts (Completed by volunteer)

Name:	
Phone Number: ( )	**Relationship:**
Name:	
Phone Number: ( )	**Relationship:**

Demographic Information (Completed by volunteer - optional)

Date of Birth: / /

-OR-

Age Range:

- ❍ *16-19*
- ❍ *20-30*
- ❍ *31-40*
- ❍ *41-50*
- ❍ *51-64*
- ❍ *65-74*
- ❍ *75-84*
- ❍ *85+*

Disabled:
- ❍ Yes ❍ No
- ❍ Decline to disclose

Gender:
- ❍ Male
- ❍ Female

Language(s) spoken (other than English):

- ❍ American Sign Language
- ❍ Tagalog
- ❍ Cambodian
- ❍ Vietnamese Cantonese
- ❍ Korean
- ❍ Mandarin
- ❍ Russian
- ❍ Spanish
- ❍ Japanese

Other language(s):

Race/Ethnicity:
- ❍ American Indian/Alaska Native
- ❍ Black/African-American
- ❍ Hispanic/Latino
- ❍ Mixed
- ❍ Native Hawaiian/Pacific
- ❍ Islander
- ❍ White/Not Hispanic Origin
- ❍ Other: _____
- ❍ Decline to disclose

Other than English, what language can you read or write? (Completed by volunteer)

Language:	❍ **Read**	❍ **Write**
Language:	❍ **Read**	❍ **Write**

How did you hear about SHIBA? (Completed by volunteer)

- ❍ CMS/Medicare
- ❍ DSHS
- ❍ Friend/Relative
- ❍ Health Fair
- ❍ Mailing
- ❍ Social Security Admin.
- ❍ Medical/Dental Provider
- ❍ Pharmacist
- ❍ Poster
- ❍ Returning Client
- ❍ SHIBA Presentation
- ❍ SHIBA Publication
- ❍ SHIBA/OIC Website
- ❍ Declines to disclose
- ❍ Internet/Website:
- ❍ Social Service Agency:
- ❍ Radio/TV:
- ❍ Newspaper:

Other:

OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

SHIBA Online Resource Record

SHIBA Resource Information (Completed by Volunteer Coordinator)	
❍ **Paid by SHIBA**	❍ **Volunteer**
❍ **In-Kind** (paid by organization)	

Volunteer/Partner Type (Reference selections on role preferences below, volunteer application, and interview discussion/notes)

Direct Service	Coordinators/Managers	
❍ **Administrative Support**	❍ **Community Partner Staff**	❍ **Program Manager**
❍ **Outreach**	❍ **Sponsor Staff (In-kind)**	❍ **Other**
❍ **Counselor**	❍ **Contract Manager**	❍ **SHIBA/OIC Staff**
❍ **Public Speaker**	❍ **Volunteer Coordinator**	
❍ **Senior Medicare Patrol (SMP) Volunteer***		

Volunteer Role Preferences (Completed by volunteer) Check all that apply.

❍ **Outreach**	❍ **Under 65**	❍ **Mentoring**
❍ **Administrative/Data Entry**	❍ **Public Speaker**	❍ **Other:**
❍ **Medicare Counseling**	❍ **Fraud Specialist (SMP) Volunteer***	

** Update SMP Volunteer spreadsheet (in Volunteer Tracking)* ❍

****** Completed by Volunteer Coordinator ******	
Security Roles	**Organization Name** (enter organization name(s) below)
❍ **View only**	❍
❍ **Volunteer – able to enter data for self**	❍
❍ **Sponsor Administrator – able to enter data for others**	❍
❍ **OIC Staff**	❍ **Office of the Insurance Commissioner** (all counties)

******Completed by SHIBA staff who created this resource record in SHIBA Online ******

SHIP Binder/Volunteer Tracking Spreadsheet updated: ❍

"New SHIBA Volunteer" email sent to:

❍ **Volunteer Coordlnator**
❍ **Regional Training Consultant**

CONFIDENTIALITY AGREEMENT FOR RECEIPT OF UNIQUE ID

I hereby agree and understand that I am accountable in protection of the privacy and confidentiality of the information that is disclosed to me pursuant to my use of the SHIP *UniqueID* which has been assigned to me by the Centers for Medicare & Medicaid Services. This ID, along with other identifying information will allow a 1-800- MEDICARE Customer Service Representative (CSR) or participating Medicare Advantage or Part D Plan sponsors to disclose certain beneficiary eligibility and claims payment-specific information to me for the purpose of assisting the beneficiary. I further understand this *UniqueID* is to be confidential and I am not to disclose this ID to anyone other than the CSR.

_____ _____

Counselor Signature Date

_____ _____

Print Name County

For SHIBA Program Office use only

_____ _____

SHIP Director Signature Date

WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633, Olympia WA 98504-2633

REQUEST FOR CRIMINAL HISTORY INFORMATION
CHILD/ADULT ABUSE INFORMATION ACT
RCW 43.43.830 THROUGH 43.43.845

A REQUESTING AGENCY/ADDRESS

WA State Office
Agency

SHIBA Program
Attn

5000 S. Capital Blvd.
Address

Tumwater, WA 98504-0256
City/State/Zip

I certify this request is made pursuant to and for the purpose indicated.

Authorized Signature Date

Title ( ) Area Code/Phone Number

B PURPOSE

Check appropriate box

- ☐ Educational School District (ESD)/School District Volunteer – no fee
- ☐ Non-Profit Business/Organization – no fee (Excluding Schools & ESD's)
- ☐ Profit Business/Organization - $17
- ☐ Adoptive Parent - $17
- ☐ Receive background results electronically

Email address

Password (must be at least 8 characters)

Fees: Make payable to **Washington State Patrol** by check, money order, or business account.

Notary letters certifying the results are available upon request. There is an additional $10.00 processing fee per notary seal.

Notarized Letter(s)

C APPLICANT OF INQUIRY (Please provide as much information as possible; name and date of birth are mandatory.)

Applicant's Name: Last First Middle

Alias/Maiden Name(s):

Date of Birth: Month/Day/Year Sex: Race:

Secondary dissemination of this criminal history record information response is prohibited unless in compliance with statute.

D WASHINGTON STATE PATROL IDENTIFICATION & CRIMINAL HISTORY SECTION

As of this date, the applicant named below has no record pursuant to RCW 43.43.830 through 43.43.845.

WA State Office of the Insurance Commissioner
Requesting Agency

Applicant's Signature

Applicant's Name

Address

City/State/Zip

3000-240-430 (R 6/12)