

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:

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

Screening process

Because your volunteer capacity with SHIBA may involve unsupervised access to vulnerable adults and/or developmentally disabled people, all prospective volunteers, including in-kind staff, will receive a national level criminal background check in accordance with RCW 43.43.830 through 43.43.845.

Prospective volunteers will receive an email invitation to complete the authorization for the background check.

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 Resource Record
- Confidentiality agreement

Email requirement

All volunteers are required to create a separate email account specifically for us as SHIBA volunteer unless they will use an agency-specific email provided by the sponsor. The purpose of this requirement is to protect your personal email and prevent unwanted disclosures of information as a result of a public disclosure request.

The format for the email name is as follows:

- Jane Marie Smith would appear as: janesshiba@gmail.com or yahoo.com; etc.
- If you receive a message “This name is already in use,” please add your middle initial: janemsshiba@email.com

Submit all completed forms

Prospective volunteers must meet with their local SHIBA Volunteer Coordinator to complete the application forms. If you need help connecting with the Volunteer Coordinator for your area, please call the SHIBA Secretary Senior if you have any questions at (360) 725-7073. We cannot process outdated or incomplete applications.

The Volunteer Coordinator will then forward the application in one of the following ways:

- 1) **Email** completed forms as a .pdf document(s) to: shiba@oic.wa.gov
- 2) **US mail:**
SHIBA Program
ATTN: Secretary Senior
PO Box 40255
Olympia, WA 98504-0255
- 3) **Fax:**(360)586-4103

Policy

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

Please be sure to follow the email requirement noted in the “Volunteer application introduction.”

*****Please write legibly – use ink*****

Personal information

First name

Last name

City

County

Zip code

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Home phone

Work phone

Cell phone

Email address

Availability – Check the days and note times you’re available to volunteer.

Time of day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Mornings							
Afternoons							
Evenings							

Employment

Employer (current or former)

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Supervisor’s name

Supervisor’s phone no.

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Home phone

Work phone

Cell phone

Education – Check all that applies

- High School
- College
- Graduate School
- Current student

Current students:

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

If yes, please describe:

Why do you want to volunteer for SHIBA?

Interests

Please tell us which areas you are interested in volunteering:

- | | |
|--|---|
| <input type="radio"/> Counseling people with Medicare | <input type="radio"/> Community outreach |
| <input type="radio"/> Data entry | <input type="radio"/> Community outreach setup/clean up |
| <input type="radio"/> Special events | <input type="radio"/> Volunteer coordinator/recruitment |
| <input type="radio"/> Counseling people (non-Medicare) | <input type="radio"/> Administrative/clerical |
| <input type="radio"/> Public speaking | <input type="radio"/> Senior fraud and abuse |
| <input type="radio"/> Phone/reception | <input type="radio"/> Other |

Special skills or qualifications

Summarize special skills and qualification acquired from employment, volunteer work or through activities including hobbies, sports, etc.:

Previous volunteer experience

Summarize your previous volunteer experience:

Reference checks

	Reference 1	Reference 2	Reference 3
Name:			
Relationship:			
Phone:			
Length of time known			

Non-affiliation – Conflict of interest statement:

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

Non-affiliation – 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 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/YYYY)

If under age 18 – Parent/legal guardian name (please print)

Signature

Date (MM/DD/YYYY)

SHIBA 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 sponsor organization name

County

I agree to the following:

I understand SHIBA is a consumer education, assistance and advocacy service of the OIC and the sponsor agency, not a policy creating or lobbying organization.

1. **Non-affiliation – 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 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 laws.

SHIBA volunteer agreement

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, nation 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 purposes 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 people served by 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)

Volunteer signature

Volunteer coordinator signature

Date (MM/DD/YYYY)

Date (MM/DD/YYYY)

****PLEASE NOTE: APPLICATION CANNOT BE PROCESSED WITHOUT VC SIGNATURE****

*****Please write legibly – use ink*****

Personal information (volunteer to complete)

Name (First/MI/Last)

Nickname or preferred name

Mailing address

City

State

Zip code

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County

Sponsor phone

Email address

Demographic information (volunteer to complete)

Date of birth (MM/DD/YYYY): _____

Gender: Male Female Other Decline to disclose

Race/ethnicity:	Primary language:	Secondary language:
<input type="radio"/> American Indian/Alaska Native	<input type="radio"/> English	<input type="radio"/> English
<input type="radio"/> Asian	<input type="radio"/> Chinese	<input type="radio"/> Chinese
<input type="radio"/> Black or African American	<input type="radio"/> Korean	<input type="radio"/> Korean
<input type="radio"/> Hispanic or Latino	<input type="radio"/> Russian	<input type="radio"/> Russian
<input type="radio"/> Native Hawaiian/other Pacific Islander	<input type="radio"/> Spanish	<input type="radio"/> Spanish
<input type="radio"/> White	<input type="radio"/> Vietnamese	<input type="radio"/> Vietnamese
<input type="radio"/> Other: _____	<input type="radio"/> Other: _____	<input type="radio"/> Other _____
<input type="radio"/> Decline to disclose		

***** This section to be completed by the volunteer coordinator *****

Partner organization affiliation: _____

Role: Volunteer coordinator Volunteer – unpaid In-kind paid by partner organizations

Dear SHIBA counselor:

Please acknowledge on the following page that you have read the:

- Confidentiality and Medicare Unique IDs
- Confidential counseling tips

Confidentiality and Medicare Unique IDs

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a federal law that protects all “individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. HIPAA has two parts:

1. Personal Protected Information (PPI)
2. Protected Health Information (PHI)

NOTE: As soon as you discover PPI or PHI is breached or potentially breached, contact the SHIBA administrative assistant at 360-725-7097 or the SHIBA programs supervisor at 360-725-7225.

Confidential counseling tips

- Use private spaces in meetings with clients to ensure confidentiality.
- Store documents containing PHI in locked offices or filing cabinets.
- Shred written notes when no longer needed.
- Discuss cases in private with authorized SHIBA advisors or Medicare Customer Service Representatives.
- Limit sharing PPI/PHI to a minimum to assist, train or report.
- Return original documents containing PPI/PHI to clients and make copies only when necessary.
- Only store PPI/PHI on password protected, authorized computers or devices.
- Only use secured Wi-Fi or an Internet connection.
- Don't use public Wi-Fi to enter or access PPI/PHI.
- Ensure computer screens are blocked from unauthorized viewers.
- Don't upload PPI/PHI to unauthorized websites.

Confidentiality agreement for MUID

I hereby agree and understand that I am accountable for protecting the privacy and confidentiality of the information that is disclosed to me pursuant to my use of the SHIP *Unique ID*, 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 sponsor to disclose certain beneficiary eligibility and claims payment-specific information to me for the purpose to assist the beneficiary. I further understand:

- My Unique *ID* is to remain confidential.
- I am not to disclose My Unique ID to anyone other than the CSR.
- Confidentiality breach is grounds for immediate dismissal.

In addition, I have read and acknowledge the:

- Confidentiality and Medicare Unique IDs (*Page 1*)
- Confidential counseling tips (*Page 1*)

Counselor name (please print)

Date (MM/DD/YYYY)

Counselor signature

County name (please print)

Counselor email address (for SHIBA use only)

***** For SHIBA Program Office Use only *****

SHIP director signature

Date (MM/DD/YYYY)