grace Hospice
Cassia ∝ Mount Olivet

weaving care, peace, and grace

Grace Hospice Volunteer Application Form

Please **email** to: gracevolunteerservices@gracecaring.org

If **mailing,** please send to: Grace Volunteer Services, 1015 4th Avenue N., #206, Mpls., MN 55405

First Name: _____ **Last Name:** _____

Telephone Number: _____ **Email:** _____

Street Address: _____ **City/State/Zip:** _____

Date of Birth (month/day/year): _____ **Occupation (former or present:** _____

Emergency Contact Name & Telephone Number: _____

Languages Spoken (in addition to English): _____

Grace Hospice Volunteers engage with patients, families and staff in a variety of ways. **Please check areas of interest:**

☐ Companionship & Support
☐ Caregiver Respite
☐ Certified Pet Therapy
☐ Pet Visit (non-certified)
☐ Other (please describe):
☐ Legacy Work (training provided)
☐ Healing Touch
☐ Vigil
☐ Death Doula (training completed)
☐ Bereavement (virtual)
☐ Quality Control (virtual)
☐ Event Planning and/or Fundraising

1. Please share your **relevant work and/or volunteer experience**, and knowledge/skills you hope to **demonstrate** as a volunteer:

2. What are the **knowledge/skills** you hope to **develop** working as a Grace Hospice volunteer?

3. Do you have experience working with **seniors**? ____ yes ____no If yes, please share details:

4. Do you have experience working with people diagnosed with **Alzheimer's and/or other forms of dementia**? ____yes _____no, **AND are you open** to working with this population? ____yes _____no

5. Is this volunteer experience for service hours? ___ Yes ____ # of Hours ___ No
   For what organization? _____

Times Available (check all that apply)

__Sunday __Monday __Tuesday __Wednesday __Thursday __Friday __Saturday

__Morning __Afternoon __Evening

Preferred Area (check all that apply)

South Metro___ East Metro____ West Metro____ North Metro_____

References - Please provide two non-family references that we may contact:

Name _____ Relation to you _____
Address/City/State/Zip _____
Daytime phone _____

Name _____ Relation to you _____
Address/City/State/Zip _____
Daytime phone _____

How did you hear about us?
_____ Cassia
_____ Mount Olivet
_____ Friend / Relative
_____ Grace Hospice Staff
_____ Grace Hospice Website
_____ Online Volunteer Platform - Name: _____
_____ Faith-based organization - Name: _____
_____ Newspaper
_____ Other - Please Identify source: _____

Confidentiality
As a Grace Hospice volunteer, I the undersigned, recognize that any information and documents I review in the course of meeting my volunteer responsibilities are to remain in the strictest confidence. No information may be released or discussed except as is necessary for fulfillment of my volunteer responsibilities. Sharing of information, documents, and/or photos requires signed releases for approval of Grace Hospice. I also understand I may not bring visitors, who are not official Grace Hospice volunteers, to visit any patient due to patient vulnerability and confidentiality.

Failure to comply with the Confidentiality Agreement will result in immediate Termination and/or legal action.

Training
I understand, in order to become a Grace Hospice Volunteer, that I will have to be trained and orientated to Grace Hospice before I am allowed to volunteer.

Certification
I agree to adhere to the confidentiality policies of Grace Hospice, and I declare my answers to the questions of this application are true. I give Grace Hospice permission to check my references and information provided.

COVID/PPE
I agree to adhere to all the safety and hygiene protocols that have been implemented by Grace Hospice.

Volunteer signature _____ Date _____