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Thank you for your interest in the MAP Volunteer Program.

Enclosed is a job description, application, and volunteer assurance about this opportunity.

Once your application has been processed, I will be in touch with you to go over any questions you may have and discuss possible training dates and times.

If you have any questions, please contact me, Anna Farha, at 405-522-4863, toll free at 1-800-763-2828 or e-mail to [anna.farha@oid.ok.gov](mailto:anna.farha@oid.ok.gov).

Please return your completed application by mail, fax or email:

**Oklahoma Insurance Department**

**400 NE 50th St**

**Oklahoma City, OK 73105**

**Fax: 405-522-4492**

**Attention: Anna Farha**

**Email:** [**anna.farha@oid.ok.gov**](mailto:anna.farha@oid.ok.gov)

**MAP VOLUNTEER APPLICATION**

Applicant Name:

Date of Birth:

Date:

**Contact Information:**

Mailing Address:

Street:

City: State:

Zip: County:

Cell Phone: ( )

Home Phone: ( )

E-Mail Address:

Shirt Size:

**Emergency Contact:**

Name:

Relationship:

Phone Number: ( )

**I. Volunteer Talents**

**A. Which of the following volunteer positions interest you? (For more details about the volunteer roles see page 8)**

* Counselor— Provides information about Medicare and related programs to beneficiaries and their families, making sure they have the necessary details to make educated decisions about their individual needs.
* Administrative Volunteer— Provide administrative support including data entry and other clerical duties.
* Outreach Assistant—Educates the community about the program and Medicare related topics.

**B. Why are you interested in volunteering for MAP?**

**C. Are you fluent in any language other than English (including sign language)?**

□ Yes (Please list which language):

□ No

**D. Skills and Interest (Please check all that apply)**

* Computer/Internet □ Public speaking with small groups
* Public speaking with large groups □ Organize/Scheduling
* Teaching/Training □ Assist individuals/direct client service
* Data Entry □ Help with Events/Booths
* General Office Work
* Other:

**E. Availability**

Hours per month: □ 4 or less □ 5 to 10 □ More than 10

Preferred days and times:

□ Monday □ Morning □ Afternoon □ Tuesday □ Morning □ Afternoon

□ Wednesday □ Morning □ Afternoon □ Thursday □ Morning □ Afternoon

□ Friday □ Morning □ Afternoon

□ As Needed

**F. Do you have a current driver’s license and have reliable transportation?**

□ Yes □ No

**G. Do you have current Liability Auto Insurance?**

□ Yes □ No

**H. State Driver License Issued In**: \_\_\_

Driver License Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. Work History and Education**

**A. Employer Information (include paid and volunteer experience)**

Retired □ Yes □ No

**1.** Company/Organization:

Dates of Service From: To:

Contact Person:

Phone: ( ) □ Paid Employee □ Volunteer

**2.** Company/Organization:

Dates of Service From: To:

Contact Person:

Phone: ( ) □ Paid Employee □ Volunteer

**B. Education**

College/Trade/Vocational:

Degree (if applicable):

**C. Optional**

Do you have any medical conditions you would like us to be aware of?

□ Yes □ No If yes, please describe:

\*Please attach Resume if applicable.

**III. References**

**Please list three references who are not related to you and not current employees or volunteers of MAP.**

**1.** Name: Relationship:

Phone: How long known:

Email:

**2.** Name: Relationship:

Phone: How long known:

Email:

**3.** Name: Relationship:

Phone: How long known:

Email:

**IV. Screening Questions**

**A. Are you currently employed at any of the following? Please check if applicable.**

* Insurance company, agent, or broker
* Financial planning service
* Health insurance claims or billing service
* Law firm or legal service organization
* Other:

**B. If you answered yes to any of the above, please explain:**

**V. Declaration**

I declare that the information provided, and statements made in this application are true and complete to the best of my knowledge and belief. I also declare that I understand that the purpose of the training I receive as a volunteer is to provide services free of charge to Medicare beneficiaries and is not to be used for my personal monetary gain.

**Signature: Date:**

**MAP Volunteer Program**

As a volunteer for MAP, I agree to act within the scope of my responsibilities and abide by all program policies and procedures as specified in, but not limited to, the following:

Volunteer job descriptions, handbooks, manuals, and other guidance. MAP is not responsible for any activity that I engage in or any responsibility that I assume other than those specified in the above mentioned program policies and procedure. Any actions that I take outside the scope of responsibility for my volunteer position will be taken at my own personal risk.

**Nature of Volunteer Service:**

* I understand that as a volunteer, I will be relied upon to serve Medicare beneficiaries and their community. The scope of responsibilities varies for each volunteer.
* I understand that my responsibilities may include providing accurate and objective counseling assistance to Medicare beneficiaries, their representatives and caregivers, or persons soon to be eligible for Medicare.
* I understand that my responsibilities may also include the use of internet-based programs to help clients compare health and prescription drug plan options.
* I understand that my responsibilities may also include educating the public on Medicare, Medicaid, and health insurance issues that affect older Americans and people with disabilities.
* I understand that my volunteer activities may need to take place at specific counseling sites, and by telephone.
* I understand that I must submit monthly documentation of my activities to my volunteer coordinator.
* I understand that volunteers provide services free of charge to any Medicare beneficiary who seeks assistance from the program.

**Confidentiality:**

* I understand that I will have access to sensitive information about my clients, including medical, insurance, financial, and other confidential personal data.
* I agree to keep such information confidential and to use it only to perform my duties as a SHIP/SMP volunteer, to the extent that a client explicitly authorizes.

**Non-Conflict of Interest:**

MAP volunteers cannot promote private or personal interests as they go about performing the duties described in the volunteer program policies and guidelines. To comply with this requirement, I agree to the following.

* I will in no way attempt to conduct market research, or solicit or persuade clients to purchase or enroll in a specific type of health insurance coverage, to switch from one carrier to another to replace existing insurance coverage, to go to a specific provider of service for treatment, or to direct a client to a specific agent/broker, or to any profit-based billing service.
* I will not disclose or use confidential or other personal information obtained from a client through my association with MAP for personal gain or the gain of my employer or any other party.

**Agreement:**

* I understand that as a volunteer, I am committing to hours each month.
* I agree to attend initial and update training program as required.
* I agree to respect the confidentiality of my clients and to exercise good faith and integrity in performing my duties as a MAP volunteer.
* I agree to complete a background check.
* I understand that a breach of this agreement will result in the termination of my volunteer service and may be subject me to liability for harm that I cause to a client through a breach of confidentiality or acting outside the scope of my responsibilities.

**Volunteer Signature:**

**Date**:

**MAP Volunteer Duties: Self-Assessment of Skills and Interests**

**Directions**: The following categories are performed by MAP volunteers. Use this list to rank the top three categories in terms of your interest in working in this category (rank your top interest No. 1, your second interest No. 2, etc.) Please note why you are interested in selected categories. For example, do you have past experience in paid or volunteer work in one of these categories? What strengths do you bring to work in one of these areas?

|  |  |  |
| --- | --- | --- |
| Top 3 Choices (Rank #1, 2, 3) | Category | Reason for Interest (Past experience or strengths in category) |
|  | Distributing information |  |
|  | Administrative assistance |  |
|  | Staffing booth exhibits |  |
|  | Group presentations |  |
|  | Counseling |  |
|  | Direct client service |  |
|  | Other |  |

**MAP Standard Volunteer Roles**

The MAP program operates with six standard volunteer roles. Information about the roles and the responsibilities connected with them are set forth in position descriptions. It is important to know that the screening process is more demanding for those roles identified as “positions of trust.” A position of trust is one in which a volunteer has access to another person’s protected personal, health care, or financial information. The five standard roles are:

* **Distributing information**: This role involves transporting and disseminating Medicare Assistance Program information materials to sites and events and may include presenting prepared copy or performing scripted activities for small groups. Volunteers who work in this role do not engage in discussions with others about personal information or situations. It is not considered to be a position of trust.
* **Assisting with administration**: This role involves such work as copying, filing, data entry, and placing outbound phone calls in support of Medicare Assistance Program activity. Volunteers who work in this role do not take inbound phone calls or field questions from the public. It is not considered to be a position of trust.
* **Staffing exhibits**: This role involves staffing information kiosks or exhibits at events such as health fairs. Volunteers who staff exhibits provide general information about Medicare Assistance Program to the public and answer simple inquiries. It is a position of trust.
* **Making group presentations**: This role involves giving substantive presentations on Medicare Assistance Program topics to small and large groups, with the opportunity for interaction with the audience during time set aside for Q & A and discussion. It is a position of trust.
* **Counseling**: This role involves direct discussion with beneficiaries about their individual situations and may include review of personal information such as Medicare Summary Notices, billing statements and other related financial and health documents. It is a position of trust.

