

2666 Riva Rd., Suite 400
Annapolis, MD 21401
Phone (410)-222-4464
TTY Users call via MD Relay 711
exjord00@aacounty.org

Pamela A. Jordan
Director

Dear Prospective Volunteer:

Thank you for your inquiry regarding the Telephone Reassurance Program. Our mission at the Anne Arundel County Department of Aging and Disabilities is to improve the quality of life of our citizens by providing options and resources to older adults and individuals with disabilities to enable them to live independent and meaningful lives. The Telephone Reassurance Program volunteers provide daily telephone well-check phone calls to these individuals to help them remain independent in their home as long as possible and to provide support to family caregivers.

In order to qualify to become a Telephone Reassurance volunteer, you must:

- Be a resident of Anne Arundel County;
- Submit a completed application;
- Have a clean background check void of any charges or convictions;
- Provide two (2) references from current or previous supervisors at time of application. (Family members cannot be used as references);
- Complete the required training.

Please contact your references and inform them they will be receiving a reference form to be completed and request they return it as soon as possible. Do **not** give the form to your references. The Telephone Reassurance Program staff will mail this form to ensure authenticity.

After we have received a clear criminal background report and positive references, you will receive a call to schedule training. Please review your application carefully to ensure you have followed all directions. Incomplete or incorrect applications will be not considered and will be returned to the applicant.

We appreciate your interest in the Anne Arundel County Department of Aging and Disabilities Telephone Reassurance Program and look forward to meeting you in the near future.

Sincerely,



Mary Chaput, Program Director



Patricia Lortie, Program Coordinator

Enclosures

- Application
- Reference Check (2)
- Criminal Background Investigation Release



TELEPHONE REASSURANCE VOLUNTEER APPLICATION

PLEASE PRINT

Name: _____ Date: _____
(Last) (First) (MI)

Street Address: _____ City and Zip: _____

Phone 1: _____ Phone 2: _____

Email Address: _____

Date of Birth: ____/____/____ Race: _____

Have you been charged/convicted of a misdemeanor or felony? Yes No

Volunteer Availability. Telephone Reassurance telephone calls are made Monday-Friday at the Department's Glen Burnie location from 7:30-10:00 am.

Please check how often you are available.

1-2 days/week 1-2 days/month

Please check the days you are available.

Monday Tuesday Wednesday Thursday Friday

Emergency Contact:

| Name | Relationship | Address | Telephone |
|------|--------------|---------|-----------|
|------|--------------|---------|-----------|

Please initial each line and sign below:

I understand that the Telephone Reassurance Program position is a volunteer position and *I am not an employee* of the Anne Arundel County Department of Aging and Disabilities.

I give the Telephone Reassurance Program permission to use my name and/or photograph in its publicity and publications.

I give the Telephone Reassurance Program permission to check reference

Signature of Volunteer Applicant

____/____/____
Date

The, Anne Arundel County Department of Aging and Disabilities does not discriminate on the basis of age, sex, race, color, religion, national origin, disability, marital status, or political affiliation.

Anyone needing accommodations must contact Mary Chaput at 410-222-4339 or by e-mail at agchap01@aacounty.org at least seven days in advance of the event. TTY users, please call via Maryland Relay 7-1-1.

VOLUNTEER'S REFERENCE FORM

THE TELEPHONE REASSURANCE PROGRAM

TO BE COMPLETED BY APPLICANT:

My signature is authorization for you to release information regarding to the Anne Arundel Department of Aging and Disabilities relative to my application for a Telephone Reassurance Program Volunteer position.

Applicant's Printed Name _____

Applicant's Signature _____ Date _____

Family members cannot be named as references.

Reference's Name: _____

Place of Employment (if applicable): _____

Mailing Address: Street _____

City/State/Zip _____

Reference Telephone: _____ Email: _____

THE TELEPHONE REASSURANCE PROGRAM WILL MAIL YOUR REFERENCES TO THE PERSON LISTED. DO NOT SEND THE TELEPHONE REASSURANCE PROGRAM COMPLETED REFERENCE FORMS. COMPLETE THIS SECTION ONLY.



The section below must be mailed to your reference by the Telephone Reassurance Program. Applicants must NOT have this section completed with the application.

The Anne Arundel County Department of Aging and Disabilities maintains a Telephone Reassurance Program which makes daily well-check telephone calls to homebound seniors and adults with disabilities. The applicant signing this form has given your name as a reference. Please complete the reference information and return in the self-addressed envelope or fax to 410-222-4358 as soon as possible. Thank you for your assistance.

TO BE COMPLETED BY REFERENCE

- How well do you know the applicant? Slightly Well Very Well
- Are you, or have you been, the applicant's Supervisor/Employer? Yes No
- Have you had any knowledge of the applicant within the past twelve months? Yes No

Please rate the applicant on the following:

- | | | | | | | | | | |
|----|----------------|--------------------------|---------------|--------------------------|---------|--------------------------|---------------|--------------------------|--------------|
| 1. | Dependability | <input type="checkbox"/> | Above Average | <input type="checkbox"/> | Average | <input type="checkbox"/> | Below Average | <input type="checkbox"/> | No Knowledge |
| 2. | Honest | <input type="checkbox"/> | Above Average | <input type="checkbox"/> | Average | <input type="checkbox"/> | Below Average | <input type="checkbox"/> | No Knowledge |
| 3. | Judgment | <input type="checkbox"/> | Above Average | <input type="checkbox"/> | Average | <input type="checkbox"/> | Below Average | <input type="checkbox"/> | No Knowledge |
| 4. | Responsibility | <input type="checkbox"/> | Above Average | <input type="checkbox"/> | Average | <input type="checkbox"/> | Below Average | <input type="checkbox"/> | No Knowledge |

Comments:

Reference Signature _____ Date _____

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Please rate the applicant on the following:

- | | | | | |
|-------------------|--|----------------------------------|--|---------------------------------------|
| 1. Dependability | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average | <input type="checkbox"/> No Knowledge |
| 2. Honest | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average | <input type="checkbox"/> No Knowledge |
| 3. Judgment | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average | <input type="checkbox"/> No Knowledge |
| 4. Responsibility | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average | <input type="checkbox"/> No Knowledge |

Comments:

Reference Signature _____ Date _____

Comments:

CRIMINAL BACKGROUND INVESTIGATION RELEASE

*I hereby authorize **Anne Arundel County Department of Aging and Disabilities and Pinkerton Consulting and Investigations**, to obtain any information pertaining to my criminal and/or civil court records. I hereby direct Pinkerton Consulting and Investigations to release such information upon request of **Anne Arundel County Department of Aging and Disabilities** or other authorized representatives of the company.*

*I hereby fully release and discharge Anne Arundel County, Maryland, its agents, assigns, employs, officers and volunteers, including the Department of Aging and any other County government source providing information to the Telephone Reassurance Program participants from any claims and damages arising out of or relating to any investigation of my background for the purpose of placement on the Telephone Reassurance Program volunteer roster. **I acknowledge that a telephone facsimile or photographic copy of this release and authorization form and the resulting investigative report shall be valid as the original.***

Minimum 7 Years of Residential History /Signature Required

PLEASE PRINT CLEARLY

| | |
|--|--|
| Name: _____ (Last, First, Middle) | Maiden/Alias: _____ (Indicate last year alias(es) was used) |
| Date of Birth: _____ | Social Security #: _____ |
| Driver's License No.: _____ | State license issued: _____ |
| Current Address: | |
| Street: _____ | |
| City/State/Zip Code: _____ County: _____ | |
| Dates at this address: From _____ To _____ | |
| Previous Address: | |
| Street: _____ | |
| City/State/Zip Code: _____ County: _____ | |
| Dates at this address: From _____ To _____ | |
| Previous Address: | |
| Street: _____ | |
| City/State/Zip Code: _____ County: _____ | |
| Dates at this address: From _____ To _____ | |
| Signature: _____ | Date: _____ |