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

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

Please rate the applicant on the following:

1.	Dependability	☐ Above Average	☐ Average	☐ Below Average	☐ No Knowledge
2.	Honest	☐ Above Average	☐ Average	☐ Below Average	☐ No Knowledge
3.	Judgment	☐ Above Average	☐ Average	☐ Below Average	☐ No Knowledge
4.	Responsibility	☐ Above Average	☐ Average	☐ Below Average	☐ No Knowledge

Comments:

Reference Signature _____ Date_____

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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:_____ Maiden/Alias:_____
(Last, First, Middle) (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:_____