DIRECTION HOME AKRON CANTON AREA AGENCY ON AGING This job description is subject to change at the Agency's discretion.	Effective: Status: Job Grade: Division: Page:	7/1/14 Volunteer N/A Elder Rights 1 of 1

JOB DESCRIPTION

Job Title:	***OMBUDSMAN REPRESENTATIVE***

Function(s):	Responsible for providing regular ombudsman presence in nursing homes, residential care facilities and adult care facilities, distributing information, and resolving uncomplicated complaints.

Responsibilities:

Responsible for providing regular ombudsman presence in nursing homes, residential care facilities and adult care facilities, distributing information, and resolving uncomplicated complaints.

1. Make regular advocacy visits to assigned nursing homes, residential care and/or adult care facilities.
2. Provide information about Long Term Care Ombudsman Program services to residents and their families through visitation, the distribution of brochures, and calling cards.
3. Speak with residents and families, gathering information about complaints and, with the resident's permission, refer to assigned Ombudsman staff. Make observations of conditions in facilities.
4. Assist residents in addressing immediate concerns by referring them, with permission, to appropriate staff within the facility for resolution or attention.
5. Attend resident and family council meetings, with residents' permission.
6. Assist in complaint handling, information gathering and follow-up while under supervision according to LTCOP policy and procedure.
7. Attend and observe Ohio Department of Health Survey Exit meetings when possible.

Other

8. Maintain and submit timely and accurate documentation of activities.
9. Complete six (6) hours of Continuing Education Training annually.
10. Perform other related duties as assigned by Volunteer Manager, Supervisor or Assigned Ombudsman mentor.

Authority and Relationships:	Responsible to the Volunteer Manager.
Position Qualifications:	Successful completion of Ohio Department of Aging Certification Training.

1550 Corporate Woods Parkway, Suite 100
Uniontown, Ohio 44685

Volunteer Application

PLEASE PRINT

Name: _____
First Middle Initial Last

Address: _____
Number and Street

_____
City State Zip

E-mail Address: _____

Home Telephone #: (_____) _____ Social Security #: _____

Work Telephone #: (_____) _____ Date Able to Start: _____

Emergency Contacts: Name: _____ Phone #: Home: _____

Name: _____ Work: _____

Cell: _____

Program for which I would like to volunteer: Long-Term Care Ombudsman Program
Any Program

Do you have a valid Ohio driver's license? ____ Yes ____ No (not necessary for positions that do not require driving)

Is your driver's license currently under suspension? ____ Yes ____ No (not necessary for positions that do not require driving)

Do you have auto insurance? ___ Yes ___ No

Have you ever been convicted of a felony? ___ Yes ___ No (If you are volunteering for a position which involves providing direct care or service to a person age sixty (60) or older, or involves significant financial responsibility, you may be required to provide a set of fingerprint impressions and a criminal records check may be conducted.)

Education

	School Name	City, State	Primary Course Work or Degree
High School			
University			

Have you ever been fired or asked to resign from any position? ___ Yes ___ No

If yes, please explain:_____

_____

Employment Experience

Company Name and ***Phone Number***	Job Title and Basic Duties	Dates Employed FROM	TO
Company Name: Phone#:			
Company Name: Phone#:			
Company Name: Phone#:			

Volunteer Experience

References

Note: Appropriate personal references should include: former employers, clergy, friends, volunteer program staff or educations.

Name	Occupation	Address, Zip Code	Phone

I hereby certify that the information given herein is to the best of my knowledge, true and accurate in every respect, and I agree that any misrepresentation, including omission of information, is sufficient cause for severance of any volunteer relationship. It is understood that nothing contained in this volunteer application is intended to create an employment contract between Area Agency on Aging 10B, Inc. and myself for either employment or for the providing of any benefit.

I understand that if I am applying for a position which involves providing direct care or service to a person age sixty (60) or older, I may be required to provide a set of fingerprint impressions and a criminal records check may be conducted. I hereby authorize Area Agency on Aging 10B, Inc. to contact listed references and to make any further investigations deemed necessary, in connection with my volunteer position and do hereby release Area Agency on Aging 10B, Inc. and all informants from all liability resulting from such investigation.

Area Agency on Aging Volunteer Statement of Confidentiality

Under no circumstances will I;

At any time either as an active or inactive volunteer, disclose the identity or personal information of any client, resident, family or complainant to anyone other then program staff without consent.

Disclose information about a long-term care facility or facility staff without the consent of the Long-Term Care Ombudsman Program.

Violation of this agreement will be just cause for suspension and/or dismissal from any Area Agency on Aging Volunteer Program.

Signature of Applicant: _____ Date: _____

SKILLS:_____

_____

HOBBIES:_____

_____

COMMUNITY INTERESTS:_____

_____

MEMBERSHIPS AND AFFILIATIONS:_____

_____

BIRTHDATE:_____

SPOUSE'S NAME (if applicable):_____

INDICATE DAY(s) AND TIME(s) YOU WOULD BE AVAILABLE TO VOLUNTEER:

Please circle: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Please circle: Morning Afternoon Evening

DIRECTION HOME
AKRON CANTON AREA AGENCY ON AGING

APPLICANT PROFILE

Area Agency on Aging, 10B, Inc. is committed to a policy of Equal Employment Opportunity that does not discriminate on the basis of race, color, religion, national origin, gender, marital status, sexual orientation, age, physical or mental disability and adheres to all applicable federal, state and local laws and regulations.

The following information will not be utilized by the Agency in its selection process. Rather, this information is collected and analyzed in aggregate form so the Agency is able to monitor the effectiveness of its recruitment process and sources. **ALL INFORMATION WILL REMAIN CONFIDENTIAL.**

PLEASE PRINT THE FOLLOWING INFORMATION:

Date: _____ Position Applying For: _____

Name: _____ Date of Birth: _____
(Last, First and Middle Initial)

Applicant Referred to Agency by:

Newspaper Ad (specify paper): _____

Recruitment Source (specify): _____

Other (specify): _____

Please check the appropriate boxes:

☐ **Male** **or** ☐ **Female**

☐ **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

☐ **White (not Hispanic or Latino):** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **Black or African American (not Hispanic or Latino):** A person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino):** A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **Asian (Not Hispanic or Latino):** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **American Indian or Alaska Native (Not Hispanic or Latino):** A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

☐ **Two or More Races (Not Hispanic or Latino):** All persons who identify with more than one of the above races.

"AN EQUAL OPPORTUNITY EMPLOYER"

Office of the State Long-Term Care Ombudsman

Conflict of Interest Screen

Please Print Clearly

Ombudsman
Stepping Up For
Elder Rights

Last name	First name	Region

Please check all that applies:

Initial screen	Annual screen	Annual screen with no change (approval attached)	Volunteer	Employee	Board member	Person(s) involved in hiring program director

1. Have you or any members of your immediate family or household ever been employed by a long-term care provider: Yes_____ No_____

If yes, please list the following:

Dates of employment	Name of person employed	Your relationship	Employer	Position/duties

2. Do you have a member of the immediate family or household that is living in a long-term care facility or is a recipient of long-term care services: Yes_____ No_____

If yes, please list the following:

Your relationship	Facility/Agency

3. Do you or any members of your immediate family or household have any financial interest in any long-term care provider or any agency that funds or regulates the long-term care services? Yes_____ No_____

If yes, please list the following:

Name of person with ownership interest/investment	Your relationship	Provider Name & Address	Description of ownership interest or investment

4. Are you or any members of your immediate family or household affiliated with, consultant to, board member of, or have any relationship in which they may profit from a long-term care provider or provider membership organization? Yes_____ No_____

If yes, please list the following:

Name of person with the affiliation	Your relationship	Provider/Organization name & address	Nature of the affiliation

5. Do you or any members of your immediate family or household stand to gain financially through an action brought on behalf of individuals that the Long-Term Care Ombudsman Program serves? Yes_____ No_____

If yes, please describe the applicable action and potential gain that may pose any actual, potential, or perceived conflict of interest.

_____

_____

_____

_____

Signed_____ **Date**_____
(Applicant/Representative)

Signed_____ **Date**_____
(Regional Program Reviewer)

Please check all that apply:

New conflict & remedy	Old conflict & remedy (approved previously)	Previously approved conflict & remedy attached	Request for waiver

Request for waiver and/or proposed remedy to the identified conflict of interest:

SLTCO Comment(s):

State Ombudsman Approval:_____ **Date:**_____

State Ombudsman Denial:_____ **Date:**_____