BALTIMORE COUNTY DEPARTMENT OF AGING
STATE HEALTH INSURANCE PROGRAM (SHIP)
VOLUNTEER REGISTRATION

VOLUNTEER INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY:	ZIP CODE:
HOME PHONE:	OTHER PHONE:	EMAIL:
BIRTH DATE:	GENDER: M F GENDER FLUID PREFER NOT TO ANSWER	
RACE: BLACK NATIVE AMERICAN/ALASKAN WHITE ASIAN HAWAIIAN/PACIFIC ISLANDER MULTIRACIAL		
ETHNICITY: HISPANIC/ LATINO YES NO		
ARE YOU BILINGUAL? YES NO IF YES, WHICH LANGUAGES:		
ARE YOU A VETERAN? YES NO		

AVAILABILITY

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

PLEASE SPECIFY TIMES WHEN AVAILABLE:

TRANSPORTATION

How far are you willing to travel to your assignment? 5 MILES 10 MILES 10+ MILES

EMERGENCY CONTACT

NAME:

PHONE: RELATIONSHIP:

CRIMINAL BACKGROUND CHECK

I hereby authorize the Baltimore County Department of Aging to perform a comprehensive background check (national criminal records check, references, and may include checks on my driving record) as required, because all of its volunteer roles are "positions of trust." In addition, I understand that RSVP will conduct both Maryland Judiciary Case Search and a National Sex Offenders Search on volunteers ages 55 and over.

DESIGNATION OF INSURANCE BENEFICIARY

NAME: RELATIONSHIP:

ADDRESS: ZIP: PHONE:

AUTHORIZATION

By signing below, I certify that all information on this registration and application is true, and I agree to keep all client information confidential. I understand that volunteers age 55 and over will be registered with the Retired and Senior Volunteer Program (RSVP). RSVP will provide a copy of the volunteer handbook which will serve as the orientation.

VOLUNTEER SIGNATURE: **DATE:**

Revised August 2024

SHIP - STATE HEALTH INSURANCE PROGRAM & SMP - SENIOR MEDICARE PATROL VOLUNTEER APPLICATION

SHIP/SMP trains volunteers to be Medicare Counselors, Part D Counselors, Speakers for Medicare Minute, and Administrative Assistants.

VOLUNTEER POSITION

Which of the following SHIP/ Senior Medicare Patrol (SMP) volunteer positions interest you?

MEDICARE PHONE COUNSELOR

MEDICARE MINUTE PUBLIC SPEAKER

MEDICARE PART D COUNSELOR

ADMINISTRATIVE ASSISTANT

(SERVING AT SENIOR CENTER LOCATIONS IN THE FALL)

WORK HISTORY/VOLUNTEER EXPERIENCE

Please list your most recent position first. Describe how each work experience can relate to your SHIP/ SMP volunteer role.

1. ORGANIZATION: YEARS _____ to _____ CITY/STATE:

   POSITION/TITLE: TYPE OF WORK:

   ROLE: PAID VOLUNTEER DESCRIPTION:

2. ORGANIZATION: YEARS _____ to _____ CITY/STATE:

   POSITION/TITLE: TYPE OF WORK:

   ROLE: PAID VOLUNTEER DESCRIPTION:

SHIP/SMP PROGRAM INTEREST/ADDITIONAL QUESTIONS

1. Why would you like to become a SHIP/ SMP volunteer?

2. Do you receive compensation for enrolling beneficiaries in a specific plan or plans? YES NO

3. How comfortable are you with using Internet search tools and techniques?

Very comfortable Somewhat comfortable Not comfortable

REFERENCES

Please provide two references, including at least one professional or work reference that is not related to you and who we may contact to ask about your qualifications.

1. NAME: PHONE: HOW LONG KNOWN:

   RELATIONSHIP:

2. NAME: PHONE: HOW LONG KNOWN:

   RELATIONSHIP:

DRIVER'S LICENSE AND CURRENT AUTOMOBILE INSURANCE CERTIFICATION

I hereby certify that I have a valid driver's license and current automobile insurance coverage. In the event my auto insurance policy lapses, I agree to notify the SHIP/SMP Program.

Current Driver's License: State: Number:

APPLICANT SIGNATURE: **DATE**