York County Area Agency on Aging
100 West Market Street
York, PA 17401
(717) 771-9610 or 1-800-632-9073
www.ycaaa.org

VOLUNTEER APPLICATION

MISSION STATEMENT: The primary focus of the York County Area Agency on Aging is to provide education, advocacy, and coordination of community based services to empower older adults to maximize their independence and quality of life.

Name: _____
Title First Name MI Last Name

Preferred Nickname: _____

Address: _____
Street

_____
City State Zip Code

Home Phone: _____ **Cell phone**: _____

Email address: _____

Preferred Method of contact: _____Home _____Cell _____Email _____Other

Emergency contact: _____
Name Relationship Phone #

Birth date: _____ **Drivers License #:** _____
Month/ Day/ Year

Languages you speak: _____

Areas of interest: (Circle areas of interest)

Peer Educator:	Special Events	Judicial Center Tour Guide
Matter of Balance Coach	Financial Counselor	Friendly Visitor
10 Keys Health Ambassador	Volunteer Ombudsman	Telephone Reassurance
Diabetes Self-Management	Scheduling Assistant	Literature Delivery
New Horizon Delivery	APPRISE (Insurance Counseling)	General Office Assistant

Previous volunteer experiences, including length of time served: _____

_____

Why do you want to volunteer for YCAAA?

_____

_____

How did you hear about us? _____

Are you active in other professional or community organizations? _____**If yes, please list organizations**: _____

Work History: If you are currently employed, please list your current job first. Use the remaining space to describe other work experiences (paid or volunteer) that relate in any way to the volunteer position. If you need additional space, please attach another sheet of paper.

Organization: _____

City/State: _____

Position/Title: _____

Type of work: _____

Years: _____ to _____

Role: _____ Paid employee _____ Volunteer _____ Other

Organization: _____

City/State: _____

Position/Title: _____

Type of work: _____

Years: _____ to _____

Role: _____ Paid employee _____ Volunteer _____ Other

I understand that acceptance to volunteer services are subject to verification of references and identity. Please list references (other than relatives) that we may contact.

1) Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

2) Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Medical Information: Do you have any medical condition or other special conditions that would affect your ability to perform your volunteer duties, or that YCAAA should be aware of: _____Yes _____No

If yes, please list: _____

_____

To ensure the safety of our clients, volunteers, and the communities we serve, applicants will be asked to consent to a background and/or criminal records check. If the position for which you apply requires a background or criminal records check, we will ask you to complete a separate form to authorize one.

I certify that the information I provided in this application is true, complete, and accurate to the best of my knowledge. I also authorize the Agency on Aging to contact the references named above with regard to my application to become a volunteer. I also authorize the persons referenced to provide information in connection with my application, and release them from any liability in regard to it. If accepted as a volunteer, I agree to follow the YCAAA's policies and procedures. I agree to attend training, as necessary, to update information necessary to my volunteer task description. I agree to maintain confidentiality concerning all information on consumers, and/ or the agency.

X _____ _____

Signature **Date**

I permit this agency to use my name and photograph as a volunteer for publicity and recognition purposes.

Yes _____ No _____