Kansas Long-Term Care
OMBUDSMAN PROGRAM

Reaching out for Quality Care

Ombudsman Volunteer Application

Contact Information

Applicant name: _____

Address: _____

City/Town _____State _____Zip code _____

Primary phone: ( ) _____- _____ Other phone: ( ) _____ -_____

Email address: _____

Best method and time to reach you: _____

Emergency contact person name:_____

Relationship: _____ Contact Phone: ( ) _____ - _____

Applicant Information

1. Please tell us about your work experience, including paid and volunteer positions.

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

   A. Organization: _____ City/State: _____
   Position/Title: _____Type of work: _____
   Years: _____ to _____ Role: _____ Paid employee _____ Volunteer

   B. Organization: _____ City/State: _____
   Position/Title: _____Type of work: _____
   Years: _____ to _____ Role: _____ Paid employee _____ Volunteer

   C. Organization: _____ City/State: _____
   Position/Title: _____Type of work: _____
   Years: _____ to _____ Role: _____ Paid employee _____ Volunteer

2. Please describe any education, skills or experience that would enable you to perform the duties of Ombudsman Volunteer. _____

_____

3. Are you fluent in any language other than English? If so, please list _____

5. Do you have access to transportation? _____

Interest in the Long-Term Care Ombudsman Program

1. How did you learn about the Long-Term Care Ombudsman program? ____ Community event _____ Ombudsman staff _____ Ombudsman volunteer _____ Newspaper _____Poster _____ Brochure _____ website _____Other: _____

2. Are you able to commit to completing 30 hours of training and to 1-3 hours of volunteer service per week? ____ Yes _____ No

Note: To ensure the safety of our clients, volunteers, and the communities we serve, applicants will be asked to consent to a criminal record check. We will ask you to complete a separate form of authorization.

Authorization and Certification

I certify that the information I provided in this application is true, complete, and accurate to the best of my knowledge. I authorize the Office of the Kansas Long-Term Care Ombudsman to contact the references named below with regard to my application to become an Ombudsman volunteer. I also authorize the persons referenced to provide information in connection with my application.

Signature: _____ Date: _____

References Please provide two references, that are not related to you and who we may contact .

Name (first, last): _____ Phone number: ( ) _____ - _____

How long known? _____ Relationship: _____

Name (first, last): _____ Phone number: ( ) ____ - _____

How long known? _____ Relationship: _____

Kansas
Department of Administration
Office of the State
Long-Term Care Ombudsman

Mail to:

Kansas LTC Ombudsman Program
900 SW Jackson, STE. 1041
Topeka, KS 66612
Phone: (785) 296-3017 or Toll Free (877) 662-8362
Email: LTCO@da.ks.gov