
SHIBA MISSION STATEMENT

The Statewide Health Insurance Benefits Advisors (SHIBA) provides free, unbiased information about health care coverage and access to help improve the lives of all Washington state residents. We cultivate community commitment through partnership, service, and volunteering.

Thank you for your interest in becoming a SHIBA volunteer! Statewide SHIBA volunteers assist in many ways to help Medicare-eligible clients make informed decisions about their own health care.

Volunteer Roles

There are many volunteer roles available to match the diverse skills, abilities and personal goals of prospective volunteers. Appropriate duties and guidance are established based on one-on-one discussions between the Volunteer Coordinator and the prospective volunteer. SHIBA will provide training appropriate to the role(s) assigned. Some typical roles to consider are:

- Administrative, data entry, clerical and technical support
- Community Outreach (education/public speaking)
- Senior Medicare Patrol (SMP) volunteer
- Counselor
- Special projects

Screening Process

All prospective volunteers will complete a Washington State Patrol (WSP) Request for Criminal History Information form and receive a background check in accordance with RCW 43.43.830 through 43.43.845. There is a section in the Volunteer Application to explain any criminal/misdemeanor offenses that may appear on a background check. SHIBA will not conduct background checks until prospective volunteers have been in contact with the Volunteer Coordinator from their local SHIBA sponsor.

PLEASE COMPLETE THE FOLLOWING FORMS:

<input type="radio"/> Volunteer Application
<input type="radio"/> Volunteer Agreement
<input type="radio"/> SHIBA Online Resource Record
<input type="radio"/> Washington State Patrol Background Authorization
<input type="radio"/> Confidentiality Agreement

SUBMIT ALL COMPLETED FORMS TO LOCAL SHIBA SPONSOR, OR

Prospective volunteers who have received the Volunteer Application Packet prior to contacting their local SHIBA sponsor may forward the completed forms in one of the following ways:

- 1) **Email** completed forms as .pdf document(s) to: shiba@oic.wa.gov
- 2) **Mail** to: SHIBA Program
ATTN: Secretary Senior
P. O. Box 0255
Olympia, WA 98504-0255
- 3) **Fax** to: (360) 586-4103

Policy

SHIBA provides equal opportunities without regard to race, creed, color, religion, national origin, gender, sexual orientation, gender identity/ expression, age, familial status, marital status, physical or mental disability, or veteran's status. **Minors under age 18** may volunteer for SHIBA with parent/guardian consent.

*****PLEASE WRITE LEGIBLY – USE INK*****

DATE (MM/DD/YY): / /

Personal Information							
Name:							
City:		County:			Zip:		
Home Phone: ()		Work Phone: ()					
Cell Phone: ()		Email:					
Availability – Check the days, note times you are available to volunteer							
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Mornings							
Afternoons							
Evenings							
Employment							
Employer (Current or former):							
Supervisor Name:				Supervisor Phone No: ()			
Position(s) held:							
Education							
<input type="radio"/> High school				<input type="radio"/> College			
<input type="radio"/> Current student				<input type="radio"/> Graduate school			
Current students:							
Is your volunteer work related to a school project or requirement: <input type="radio"/> Yes <input type="radio"/> No							
If yes, please describe:							

Why do you want to volunteer for SHIBA?	
Interests	
Please tell us which areas you are interested in volunteering	
<input type="radio"/> Data entry	<input type="radio"/> Phone/reception
<input type="radio"/> Special events	<input type="radio"/> Community outreach
<input type="radio"/> Counseling people with Medicare	<input type="radio"/> Community outreach set up/clean up
<input type="radio"/> Counseling people (non-Medicare)	<input type="radio"/> Volunteer coordination/recruitment
<input type="radio"/> Public speaking	<input type="radio"/> Administrative/clerical
<input type="radio"/> Senior Fraud and Abuse - Senior Medicare Patrol (SMP)	
<input type="radio"/> Other	
Special Skills or Qualifications	
Summarize special skills and qualifications acquired from employment, volunteer work, or through activities, including hobbies, sports, etc.	
Previous Volunteer Experience	
Summarize previous volunteer experience.	
Reference Checks	
Name:	Phone: ()
Relationship:	Length of Time Known:
Name:	Phone: ()
Relationship:	Length of Time Known:
Name:	Phone: ()
Relationship:	Length of Time Known:

NON-AFFILIATION – CONFLICT OF INTEREST STATEMENT

Statewide Health Insurance Benefits Advisors (SHIBA) provides health insurance information via volunteers who are not professionals in the field but are trained by the Washington State Office of the Insurance Commissioner.

NONAFFILIATION – CONFLICT OF INTEREST: I do not have an active insurance license. I will act in good faith without selling, recommending, or endorsing any specific insurance product, agency, or related service. Nor am I currently affiliated with or employed by a health insurance company, agency or service, nor am I in a position to sell or receive commissions from health insurance products or services, or use my SHIBA affiliation for purposes of personal financial gain.

By submitting this application, I affirm the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

I, the undersigned, understand that all statements I make in response to this inquiry are subject to investigation and verification prior to appointment. I further understand the SHIBA program may make an inquiry to the Washington State Patrol to verify any record for convictions of offenses, adjudications or abuse in a civil action, or disciplinary board final decision. I do hereby certify, under penalty of perjury, that my responses to this inquiry are true and correct to the best of my knowledge, in accordance with RCW 43.43.834.

Name (please print):	
Signature:	Date (mm/dd/yy): / /

If under age 18 -

Parent/Legal Guardian (please print):	
Signature:	Date (mm/dd/yy): / /

The purpose of this agreement is to ensure a common understanding between the Sponsor organization, the Washington State Office of the Insurance Commissioner (OIC), the Statewide Health Insurance Benefits Advisors (SHIBA) and the Volunteer.

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Volunteer Name: First, MI, Last (please print legibly):

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SHIBA Sponsoring Organization Name

County

I agree to the following:

I understand SHIBA is a consumer education, assistance and advocacy service of the Office of the Insurance Commissioner (OIC) and the sponsoring agency, not a policy creating or lobbying organization.

1. NONAFFILIATION – CONFLICT OF INTEREST

I do not have an active insurance license. I will act in good faith without selling, recommending or endorsing any specific insurance product, agency, or related service. Nor am I currently affiliated with or employed by a health insurance company, agency or service, nor am I in a position to sell or receive commissions from health insurance products or services, or use my SHIBA affiliation for purposes of personal financial gain.

2. IMPARTIALITY

If in the future I become affiliated with an insurance company, agency or service, or I'm in a position to use my SHIBA affiliation for personal financial gain, I will terminate my position with SHIBA. Also, I will remain impartial, refraining from advising or expressing my opinions regarding a consumer's course of action.

3. CONFIDENTIALITY

I will not disclose any identifying client personal information to anyone outside the SHIBA organization without the client's authorization in accordance with state and federal law.

4. **NON DISCRIMINATION**

I understand the act of favoritism or making a difference in treatment based on an individual's race, creed, color, religion, gender, national origin, age, sexual orientation, gender identity, expression, familial status, marital status, physical or mental disability, political party, or veteran's status is not permitted.

5. **LOBBYING**

I agree that I will not use public resources for political campaigns, to support or oppose candidates, ballot issues, or political causes. No one may use or authorize the use of facilities of an agency, directly or indirectly, for the purpose of assisting a campaign for election of a person to an office or for the promotion of or opposition to a ballot proposition. I understand that I may be asked to provide information that identifies the affects of current or future legislation to OIC staff for their information. Resources include, but are not limited to, stationary, postage, machines, equipment, state employees or volunteers during working hours, vehicles, office space, publications of the agency, and clientele lists of persons served by the SHIBA or the OIC.

I understand that I may be asked by staff to provide information that identifies the effects of current or future legislation, regulation, or program changes to OIC staff to support advocacy and consumer protection efforts.

Volunteer (print name)

Volunteer Coordinator (print name)

Signature

Signature

Date

Date

- Complete SHIBA Online Resource Record
- Complete WSP Background Check Authorization

*** Completed by SHIBA program staff only ***

NPR No:

Background check cleared (MM/DD/YY): / /

PLEASE WRITE LEGIBLY – USE INK

Personal Information (Completed by volunteer)			
Name:			
Mailing Address:			
City:		County:	
Home Phone: ()		Work Phone: ()	
Cell Phone: ()		Email:	
Emergency Contacts (Completed by volunteer)			
Name:			
Phone Number: ()		Relationship:	
Name:			
Phone Number: ()		Relationship:	
Demographic Information (Completed by volunteer - optional)			
Date of Birth: / /		Disabled:	Gender:
-OR-		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Decline to Disclose	<input type="radio"/> Male <input type="radio"/> Female
Age Range:		Language(s) spoken (other than English):	
<input type="radio"/> 16 - 19 <input type="radio"/> 51 - 64 <input type="radio"/> 20 - 30 <input type="radio"/> 65 - 74 <input type="radio"/> 31 - 40 <input type="radio"/> 75 - 84 <input type="radio"/> 41 - 50 <input type="radio"/> 85+		<input type="radio"/> American Sign Language <input type="radio"/> Korean <input type="radio"/> Tagalog <input type="radio"/> Mandarin <input type="radio"/> Cambodian <input type="radio"/> Russian <input type="radio"/> Vietnamese <input type="radio"/> Spanish <input type="radio"/> Cantonese <input type="radio"/> Japanese <input type="radio"/> Other language(s):	
Race/Ethnicity:			
<input type="radio"/> American Indian/Alaska Native <input type="radio"/> Black/African-American <input type="radio"/> Hispanic/Latino <input type="radio"/> Mixed <input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> White/Not Hispanic Origin <input type="radio"/> Other: _____ <input type="radio"/> Decline to Disclose			
Other than English, what language can you read or write? (Completed by volunteer)			
Language:		<input type="radio"/> Read	<input type="radio"/> Write
Language:		<input type="radio"/> Read	<input type="radio"/> Write
How did you hear about SHIBA? (Completed by volunteer)			
<input type="radio"/> CMS/Medicare	<input type="radio"/> Social Security Admin.	<input type="radio"/> SHIBA presentation	<input type="radio"/> Internet/Website:
<input type="radio"/> DSHS	<input type="radio"/> Medical/Dental Provider	<input type="radio"/> SHIBA publication	<input type="radio"/> Social Service Agency:
<input type="radio"/> Friend/Relative	<input type="radio"/> Pharmacist	<input type="radio"/> SHIBA/OIC website	<input type="radio"/> Radio/TV:
<input type="radio"/> Health fair	<input type="radio"/> Poster	<input type="radio"/> Declines to disclose	<input type="radio"/> Newspaper:
<input type="radio"/> Mailing	<input type="radio"/> Returning client	<input type="radio"/> Other:	

Volunteer Role Preferences (Completed by volunteer) (Check all that apply)		
<input type="radio"/> Outreach	<input type="radio"/> Under 65	<input type="radio"/> Mentoring
<input type="radio"/> Administrative/Data Entry	<input type="radio"/> Public Speaking	<input type="radio"/> Other:
<input type="radio"/> Medicare Counseling	<input type="radio"/> Fraud Specialist (SMP Volunteer)*	

SHIBA Resource Information (Completed by Volunteer Coordinator)	
<input type="radio"/> Paid by SHIBA	<input type="radio"/> Volunteer
<input type="radio"/> In-Kind (paid by organization)	

Volunteer/Partner Type (Reference selections on role preferences below, volunteer application, and interview discussion/notes)		
Direct Service	Coordinators/Managers	
<input type="radio"/> Administrative Support	<input type="radio"/> Community Partner Staff	<input type="radio"/> Program Manager
<input type="radio"/> Outreach	<input type="radio"/> Sponsor Staff (In-kind)	<input type="radio"/> Other
<input type="radio"/> Counselor	<input type="radio"/> Contract Manager	<input type="radio"/> SHIBA/OIC Staff
<input type="radio"/> Public Speaker	<input type="radio"/> Volunteer Coordinator	
<input type="radio"/> Senior Medicare Patrol (SMP) Volunteer*		

* Update SMP Volunteer spreadsheet (in Volunteer Tracking) Done

*** Completed by Volunteer Coordinator or SHIBA Staff ***	
Security Roles	Organization Name (enter organization name(s) below)
<input type="radio"/> View only	<input type="radio"/>
<input type="radio"/> Volunteer	<input type="radio"/>
<input type="radio"/> Sponsor Administrator	<input type="radio"/>
<input type="radio"/> OIC Staff	<input type="radio"/> Office of the Insurance Commissioner (all counties)

*****Completed by SHIBA staff who created this resource record in SHIBA Online *****

SHIP Binder/Volunteer Tracking Spreadsheet updated:	<input type="radio"/> Yes
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<p>“Welcome to SHIBA” email sent to:</p> <p><input type="radio"/> Volunteer</p> <p><input type="radio"/> Volunteer Coordinator</p> <p><input type="radio"/> Regional Training Consultant</p>
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WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633, Olympia WA 98504-2633



REQUEST FOR CRIMINAL HISTORY INFORMATION CHILD/ADULT ABUSE INFORMATION ACT RCW 43.43.830 THROUGH 43.43.845 (Instructions on Reverse Side)

<p>(A) REQUESTING AGENCY/ADDRESS</p> <p><u>WA State ofc. of Ins. Comm</u></p> <p>Agency <u>STHBA Program</u></p> <p>Attn <u>5000 S. Capital Blvd</u></p> <p>Address <u>Tumwater, WA 98504-0256</u></p> <p>City/State/Zip</p> <p>I certify this request is made pursuant to and for the purpose indicated.</p> <p>_____ Authorized Signature Date () _____ Title Area Code/Phone Number</p>	<p>(B) PURPOSE Check appropriate box</p> <p><input type="checkbox"/> Educational School District (ESD)/School District Volunteer – no fee</p> <p><input checked="" type="checkbox"/> Non-Profit Business/Organization – no fee (Excluding Schools & ESD's)</p> <p><input type="checkbox"/> Profit Business/Organization - \$35</p> <p><input type="checkbox"/> Adoptive Parent - \$35</p> <p>Fees: Make payable to Washington State Patrol by check, money order, or business account.</p> <p>Notary letters certifying the results are available upon request. There is an additional \$5.00 processing fee per notary seal.</p> <p>_____ Notarized Letter(s)</p>
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(C) APPLICANT OF INQUIRY (Please provide as much information as possible; name and date of birth are mandatory.)

Applicant's Name: _____
Last First Middle

Alias/Maiden Name(s): _____

Date of Birth: _____ Sex: _____ Race: _____
Month/Day/Year

Social Security Number: _____ (optional) Driver's Lic. Number/State: _____ / _____
OR ID#

Secondary dissemination of this criminal history record information response is prohibited unless in compliance with statute.

(D) WASHINGTON STATE PATROL IDENTIFICATION & CRIMINAL HISTORY SECTION

WSP Use Only

As of this date, the applicant named below has no record pursuant to RCW 43.43.830 through 43.43.845.

WA State ofc. of Ins. Comm.
Requesting Agency

Applicant's Signature

Applicant's Name

Address

City/State/Zip

Applicant Right Thumb Print (Optional)

Prospective STHBA Volunteers complete highlighted fields.

CONFIDENTIALITY AGREEMENT FOR RECEIPT OF UNIQUE ID

I hereby agree and understand that I am accountable in protection of the privacy and confidentiality of the information that is disclosed to me pursuant to my use of the SHIP *UniqueID* which has been assigned to me by the Centers for Medicare & Medicaid Services. This ID, along with other identifying information will allow a 1-800-MEDICARE Customer Service Representative (CSR) or participating Medicare Advantage or Part D Plan sponsors to disclose certain beneficiary eligibility and claims payment-specific information to me for the purpose of assisting the beneficiary. I further understand this *UniqueID* is to be confidential and I am not to disclose this ID to anyone other than the CSR.

Counselor Signature

Date

Print Name

County

For SHIBA Program Office use only

SHIP Director Signature

Date