

**HANDS ON! THE HUDSON VALLEY  
LONG TERM CARE OMBUDSMAN PROGRAM  
VOLUNTEER APPLICATION**

Please Print

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ COUNTY \_\_\_\_\_

ZIP CODE : \_\_\_\_\_ EMAIL: \_\_\_\_\_

TELEPHONE NO: \_\_\_\_\_ CELL PHONE NO.: \_\_\_\_\_

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1. Are you 21 years of age or older? \_\_\_\_\_ 2. Do you have transportation? \_\_\_\_\_

2. Briefly describe your employment/life experience: \_\_\_\_\_  
\_\_\_\_\_

3. Foreign language(s) spoken? \_\_\_\_\_

4. Have you ever been a volunteer? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

5. Have you any experience with long term care, the elderly or mental health clients? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

6. Do you or a family member have a personal/financial interest in any long term care facility? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

7. Is a member of your family in a long-term care facility at this time? \_\_\_\_\_

If yes, where is the facility: \_\_\_\_\_

8. Can you commit 36 hours for the initial Certification Training? \_\_\_\_\_

9. Can you commit 3-4 hours per week to the Ombudsman Program? \_\_\_\_\_

10. Can you commit to attend on-going training for 1-2 hours six times per year? \_\_\_\_\_

11. How did you learn about the Ombudsman program? \_\_\_\_\_  
\_\_\_\_\_

12. List some of the reasons why you wish to become a NYS Certified Ombudsman; \_\_\_\_\_  
\_\_\_\_\_

13. Briefly describe what you hope to gain from this volunteer experience: \_\_\_\_\_  
\_\_\_\_\_

14. Do you have any health related issues that you feel we should be aware of? \_\_\_\_\_

If yes, please briefly describe: \_\_\_\_\_  
\_\_\_\_\_

Please provide information for two (2) non-relative references that we may contact to discuss your participation in the Long Term Care Ombudsman Program.

1. Name: \_\_\_\_\_

Nature of Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

2. Name: \_\_\_\_\_

Nature of Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please return completed form to:

Hands On! The Hudson Valley  
Long Term Care Ombudsman Program  
7 Pine Woods Rd. Suite 3C  
Hyde Park, NY 12538 OR Fax: (845) 229-4684

**THANK YOU FOR YOUR INTEREST – IF YOU HAVE ANY QUESTIONS PLEASE CONTACT US  
845-229-4680**