Medicare Information Office

State Health Insurance Program/Senior Medicare Patrol Application

Date: _____

Thank you for your interest in becoming an Alaska SHIP/SMP volunteer or partner agency. We provide free, unbiased, confidential couseling to anyone with questions about Medicare.

Name (Last, First MI):	Email Address:	
Phone Numbers:		
Address (Include Zip Code):		
Agency Affiliation (if any)		
Languages Spoken	languages Read	Languages Written
Emergency Contact Name:	Phone:	Relationship:

References:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Areas of Interest Within Our Volunteer Roles: (Please check all that apply)

☐ Counseling ☐ Assisting with Administration ☐ Staffing Exhibits

☐ Making Group Presentations ☐ Handling Complex Issues ☐ Distributing Information

☐ Other (Please Specify): _____

If applying for volunteer role, How often would you like to volunteer?

How many hours are you available for volunteer assignments?

Hours per week: _____ Hours per Month: _____

Check the days and times you are available for volunteer assignments.

	Monday	Tuesday	Wednesday	Thursday	Friday
Mornings	☐	☐	☐	☐	☐
Afternoons	☐	☐	☐	☐	☐

How did you hear about volunteering at the Medicare Information Office?

☐ Website ☐ Newspaper ☐ Word of mouth ☐ Community presentation

☐ Friend/Relative ☐ Radio/TV Ad ☐ Other (explain): _____

Do you have any physical limitations? _____. If yes, please explain,

_____

_____

Background Check Policy

The Medicare Information Office conducts background checks on all applicants for volunteer positions that involve peoples' personal, medical, and financial information, including a criminal records check and sex offender registry search.
Have you ever been convicted of any crimes, felonies, or misdemeanors? _____No _____Yes

If yes, please explain: _____

_____

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 also authorize the Medicare Information Office to contact the references named below regarding 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 regarding it.
Signature: _____ Date: _____

Email, Fax, or Mail Completed Application to:
hss.medicare@alaska.gov • 1835 Bragaw Street, Suite 350, Anchorage, AK 99508
Fax: (907) 269-2045 • Phone: 1-800-478-6065 or (907) 269-3680

SHIP State Health Insurance Assistance Program Navigating Medicare

SMP Senior Medicare Patrol Preventing Medicare Fraud