



Team Member Application

Please note that the Virginia Insurance Counseling and Assistance Program (VICAP) does not accept applications from insurance agents, insurance brokers, or financial planners.

Applicant's Name: _____

Date: _____ **County:** _____

I. Interests and Experience

A. Which VICAP COMPASS Team member position(s) are of interest to you:

- Counselor** - Provides one-on-one assistance to help people navigate Medicare and related health insurance programs
- Outreach Assistant** - Educates the community about VICAP, Medicare, and related health insurance programs
- Marketer** - Promotes community awareness of VICAP, its services, and volunteer opportunities
- Part D Specialist** - Provides one-on-one assistance to help people navigate Medicare prescription drug coverage
- Administrative Assistant** - Provides administrative and program support, including data entry and other clerical duties
- Specialized Counselor** - Provides one-on-one assistance about a specific health insurance topic
- Site Manager** - Provides overall leadership and management for a satellite VICAP site

B. Why are you interested in volunteering with the VICAP COMPASS Team?

C. Are you fluent in any language other than English (including sign language)?

Yes No *If yes, please list language(s):* _____

D. Skills and Interests (Please check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Computer/Internet | <input type="checkbox"/> Organizing/Scheduling |
| <input type="checkbox"/> Public speaking with large groups | <input type="checkbox"/> Public speaking with small groups |
| <input type="checkbox"/> Public relations/Communications | <input type="checkbox"/> Research |
| <input type="checkbox"/> Teaching/Training | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Data Entry | <input type="checkbox"/> Graphic Design |
| <input type="checkbox"/> General Office Work | |
| <input type="checkbox"/> Assist individuals/One-on-one direct client service | |
| <input type="checkbox"/> Other _____ | |

E. Experience (include paid and volunteer experience starting with the most recent)

Company/Organization: _____

Dates of service: From _____ to _____

Contact person: _____ Phone: _____

- Paid employee Volunteer

Company/Organization: _____

Dates of service: From _____ to _____

Contact person: _____ Phone: _____

- Paid employee Volunteer

F. Availability

Hours per month: 4 or less 5 to 10 More than 10

Preferred days and times:

- | | | | |
|------------------------------------|----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sunday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> Monday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> Tuesday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> Wednesday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> Thursday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> Friday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> Saturday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> As Needed | | | |

G. Are you licensed and able to drive an automobile? Yes No

II. Personal Information

A. Contact Information

Name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Email: _____

Home phone: _____ Cell phone: _____

B. Employer Information (if currently employed)

Occupation: _____

Company/Organization: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

C. Education

College/University (if any): _____

Degree/Major: _____

Dates attended: _____ Graduated? Yes No

High School: _____

Dates attended: _____ Graduated? Yes No

D. Emergency Contact

Name: _____ Relationship: _____

Home phone: _____ Other phone: _____

E. Optional

Do you have any medical conditions you would like VICAP to be aware of?

Yes No

If yes, please describe: _____

Do you require any special accommodations? Yes No

If yes, please describe: _____

III. References

Please list two references, who are not related to you.

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

IV. Conflict of Interest Screening Questions

A. Are you affiliated with any of the following:

- | | | |
|--|------------------------------|-----------------------------|
| Insurance company, agency or broker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Financial planning service | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Health insurance claims or billing service | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Law firm or legal services organization | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other (<i>please describe</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
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B. Have you ever been convicted of a crime or offense? Yes No

C. If you answered yes to any of the above, please explain: _____

V. Declaration

I declare that the information provided and statements made in this application are true and complete to the best of my knowledge and belief. I also declare that I understand that the purpose of the training I receive as a VICAP COMPASS Team member is to provide services free of charge to Medicare beneficiaries and is not to be used for my personal monetary gain. I also understand that VICAP is not required to accept all applicants for placement in team member positions.

Applicant's Signature: _____ Date: _____

Coordinator Signature: _____ Date: _____

Please mail or fax this form to: