HANDS OF HOPE RESOURCE CENTER
VOLUNTEER ADVOCATE APPLICATION

Name

Home phone

Address

Cell phone

Email address

Work phone

Birthdate

Can you be called at work?

Days and hours you can be reached

What is (are) your reason(s) for volunteering for this program?

Have you had previous volunteer experience?

Have you volunteered with another victims program?

If yes to either of these questions, please list what you did and why you stopped.

What can you gain from being a volunteer and what do you feel you can give to the program?

Do you have a particular preference for the kind of work you would do in the program (e.g. public speaking, writing, one-to-one advocacy, other)?

Please describe any areas about which you have strong feelings (e.g. abortion, gay/lesbian lifestyles, suicide, drug abuse, therapy, teenage sex, etc.).

Are there any kinds of people you feel uncomfortable around? If yes, please describe.

How will you be supportive of victim/survivors who have views, values, and/or lifestyles differing from your own?

If you have been affected by any form of abuse, please explain how are you dealing with or have dealt with the victimization.

Have you ever had any special training (e.g., bi-lingual skills, business trade, public speaking, communication skills, counseling, etc.) that would be relevant to working in the area of domestic violence, sexual assault, child abuse, or general crime? Please describe.

Do you have a valid MN driver's license?

License number

Do you have access to a car in safe operating condition?

Name of insurance company

Policy number

Amount of liability coverage

Have you ever been convicted of a crime?

If yes, describe in full:

(Information concerning this question will not be used to automatically bar you from volunteering.)

How much time can you give to the program per month?

Are you able to attend a monthly meeting held the second Tuesday of each month?

Are you willing to make a minimum one year commitment to the program?

Please list 2 references, how they know you, and how they can be reached. These people will be contacted:

I realize that the identity and circumstances of any victim/survivor(s) that I may have contact with or become aware of as a result of my participation in Hands of Hope Resource Center must be kept completely confidential. Any breach of this policy will result in my dismissal from the program.

Signature

Date

PLEASE RETURN TO:

HANDS OF HOPE RESOURCE CENTER
Attn: Amanda
P.O. Box 67
Little Falls MN 56345
PHONE 320-632-1657
FAX 320-632-5457
E-MAIL: amanda.handsofhope@co.todd.mn.us