

HANDS OF HOPE RESOURCE CENTER – VOLUNTEER ADVOCATE APPLICATION
MORRISON/TODD COUNTY
P.O. BOX 67
LITTLE FALLS, MN 56345

NAME: _____ HOME PHONE: _____

ADDRESS: _____ BUSINESS PHONE: _____

e-mail _____ BIRTH DATE: _____ Can you be called at work? _____

Days and hours you can be reached. _____

(Please use an additional sheet of paper if you need more room in answering any of the following questions.)

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

2. Have you had previous volunteer experience? YES _____ NO _____

Have you volunteered with another victims program? YES _____ NO _____

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

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

4. 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)? _____

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

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

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

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

9. 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. _____

10. Do you have a valid MN driver's license? YES ___ NO ___ LICENSE NUMBER _____
Do you have access to a car in safe operating condition? YES ___ NO ___
Name of insurance company _____ Policy # _____
Amount of liability coverage _____

11. 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.

12. How much time can you give to the program per month? _____
Are you available for training on Tues. & Thurs. evenings & 2 Saturdays? YES ___ NO ___
Are you able to attend a monthly meeting held the second Wednesday of each month?
YES ___ NO ___
Are you willing to make a minimum one year commitment to the program? YES ___ NO ___

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: Karla

P.O. Box 67

Little Falls, MN 56345

PHONE 320-632-1657 or 1-800-296-1657 FAX 320-632-5457

E-MAIL karla.handsofhope@co.todd.mn.us