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

NAME: _____ PRIMARY PHONE: _____

ADDRESS: _____BUSINESS PHONE: _____

E-MAIL: _____ BIRTH DATE: _____

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 victim's 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 like to do in the program (e.g., public speaking, crisis line, one-to-one advocacy, other)? _____

_____

5. Please describe any areas about which you have strong feelings (e.g., abortion, LGBTQIA+, 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 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_____

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 able to attend a monthly meeting held the second Tuesday 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: Rocio**
**P.O. Box 67**
**Little Falls MN 56345**
**PHONE 320-632-1657**
**FAX 320-632-5457**
**E-MAIL: rocio@handsofhope.net**

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