NJ STATE HEALTH INSURANCE ASSISTANCE PROGRAM

SHIP PROSPECTIVE COUNSELOR APPLICATION

Applicant's Name: _____

(Please Print Clearly)

Date of Birth: _____

County You Intend to Counsel In: _____

Contact Information

Mailing address: _____

City: _____State:_____ Zip Code: _____

E-mail: _____

Home phone: (___) ___-____ Cell phone: (___) ___-____

Volunteer Talents

A. Why are you interested in volunteering with SHIP?

_____

_____

_____

B. Do you have any previous volunteer experiences? If so, please describe.

_____

_____

_____

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

Skills and Interests

A. Can you navigate the Internet? ☐ Yes ☐ No

B. Do you have access to E-mail at your home or office (not a public computer)? ☐ Yes ☐ No

C. Would you be interested in public speaking to small groups? ☐ Yes ☐ No

D. Would you be interested in inputting information in the computer? ☐ Yes ☐ No

Screening Questions

Are you <u>currently</u> employed or <u>affiliated</u> with any of the following:

A. Insurance company, agency or broker? ☐ Yes ☐ No

B. Are you a licensed insurance producer? ☐ Yes ☐ No (This information will be verified by the New Jersey Department of Banking and Insurance.)

C. Financial planning service? ☐ Yes ☐ No

D. Health insurance claims or billing service? ☐ Yes ☐ No

E. Pharmaceutical industry? ☐ Yes ☐ No

F. Law firm or legal services organization? ☐ Yes ☐ No

G. Geriatric Care Manager? ☐ Yes ☐ No

H. Other? (Please describe) _____

Experience

Current work status: Full time ☐ Part time ☐ Student ☐

Retired ☐ Unemployed ☐

Current or Former Occupation: _____

If working, company/organization:_____

Education

Highest Level of Education:

High School/GED ☐ College ☐ Post Graduate ☐

Education: degrees, special training: _____

Availability

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

☐ **Monday**	☐ **Morning**	☐ **Afternoon**
☐ **Tuesday**	☐ **Morning**	☐ **Afternoon**
☐ **Wednesday**	☐ **Morning**	☐ **Afternoon**
☐ **Thursday**	☐ **Morning**	☐ **Afternoon**
☐ **Friday**	☐ **Morning**	☐ **Afternoon**
☐ **as needed**	☐ **Morning**	☐ **Afternoon**

Important Note: We are asking for a commitment of at least 12 months.

References

Please list two (2) references that are not related to you.

Name: _____

Phone: (___) ___-____ Relationship: _____

Name: _____

Phone: (___) ___-____ Relationship: _____

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 SHIP training, and any materials I receive as a SHIP volunteer counselor, is to provide services free of charge to Medicare beneficiaries , or their representatives, and is not to be used for my personal monetary gain.

Signature: _____ Date: _____

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If interested, please complete this application and return it to your local SHIP Coordinator at the address below:

Coordinator: Please insert a label here with your name and address listed. Also, include SHIP brochure with this packet.