Office Use Only:

I: \_\_\_\_\_\_\_\_\_ B: \_\_\_\_\_\_\_\_\_\_\_\_\_

R: \_\_\_\_\_\_\_\_\_ T: \_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Volunteer Application Form**

Companion Program

**WHO WE ARE**

Plymouth Healing Communities offers housing and companionship to individuals living with mental illness, breaking the cycle of hospitalization and homelessness, and providing a positive alternative to shelters and the street.

**House of Healing Program**: We provide companionship and deep respect in a small, referral-based, neighborhood-scaleshelter, to homeless patients released from Harborview's inpatient psychiatric units and outpatient mental health clinic following an acute episode of mental illness.

**Community Companion Program**: We provide companionship and deep respect to individuals touched by our programincluding individuals who have moved on from the House of Healing and those who live in our permanent housing properties. Volunteers are paired either individually or in teams to provide companionship to help prevent isolation and fight stigma.

**YOUR CONTACT INFORMATION**

**Name:**  Click here to enter name.

**Address:** Click here to enter current address.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  **Phone number:** |  | Enter phone number. |  | Email address: | Click here to enter email. |
| **Best way to reach you:** | [ ]  **Email** | [ ] **Phone** | [ ]  **No Preference** |

**Date of Birth:** Click here to enter text. (Note: Volunteers must be over 18 years of age.)

**Emergency Contact:** **Name:** Click here to enter text.

 **Relationship:** Click here to enter text.

**Phone number:** Click here to enter text.

**TELL US ABOUT YOURSELF**

**1. Check the box of the program you’re interested in:**

 [ ] House of Healing Respite Program [ ] Community Companion Program [ ] Both

1. **How did you learn of Plymouth Healing Communities and the volunteer opportunities?**

Click here to tell us how you found out about PHC.

**3. Why are you interested in serving as a volunteer companion?**

 Click here to tell us why you want to get involved with PHC.

1. **Please comment on any prior volunteer roles you have held. Why do you serve? Please describe any experience you have around mental illness and/or homelessness (experience in these fields is not required).**

 Click here to tell us about your volunteer experience.

1. **Please describe your experience and comfort in relating to people of different backgrounds than your own. What is your perspective on diversity?**

Click here to describe your experience.

1. **What skills, knowledge, and sensitivities do you see yourself contributing to the intentional community at Plymouth Healing Communities?**

Click here to tell us about your skills and knowledge.

**7. Please list any current work and/or volunteer commitments:**

List current work and volunteer commitments.

**8. Please indicate the days and times that you are typically available (check all that apply):**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Morning(8am-1pm) |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Afternoon(1pm-6pm) |[ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Evening(6pm-10pm) |[ ] [ ] [ ] [ ] [ ] [ ] [ ]

1. **For liability reasons, we conduct a background check on each volunteer. Are you willing to provide information we might need for this process?**

[ ]  Yes [ ] No Comments: Click here to enter comment.

1. We strive to support and make appropriate accommodations for our volunteers’ needs. Do you have any health limitations or other needs that you would like us to be aware of?

[ ]  Yes [ ] No Comments: Click here to enter comment.

**COMMITMENT**

Are you able to attend a 1 day required volunteer training session? (Typically a Saturday from 9A-4P)

[ ]  Yes [ ] No Comments: Click here to enter comment.

Are you available to commit to volunteering approximately 8-10 hours per month?

[ ]  Yes [ ] No Comments: Click here to enter comment.

Can you commit to one year of companionship? Please comment on any foreseeable interruptions to your service.

[ ]  Yes [ ] No Comments: Click here to enter comment.

**PROVIDE TWO REFERENCES**

**Professional Reference** *(e.g. employer, teacher, volunteer supervisor)*

**Name:**  Click here to enter name.

**Title:**  Click here to enter title. **Organization**: Click here to enter organization.

**Phone**: Click here to enter phone.  **Email:** Click here to enter text.

**Relationship:** How do you know this reference? **How long have you known this person**? Enter number

**Personal Reference** *(e.g. friend or relative)*

**Name:** Click here to enter name.

**Title:** Click here to enter title.

**Phone:**  Click here to enter phone. **Email:** Click here to enter name.

**Relationship:** How do you know this reference? **How long have you known this person**? Enter number

**OTHER**

Is there anything else you would like us to know? Click here to enter text.

**SIGNATURE**

Your signature certifies that the information you provided is complete and accurate to the best of your knowledge.

Printed Name Electronic Signature Here. Date of Signature.

Name (Printed) Signature (electronic) Date

Thank you for sharing yourself with us! We appreciate your interest in our work.

**NEXT STEPS**

**Please attach a copy of your resume with your application.**

**House of Healing Respite Program Applicants**

Please submit your application electronically to volunteer@plyhc.org and we will schedule a time to interview.

If you have any questions about the Companion Program or your application, please contact us via email at volunteer@plyhc.org or (206) 622-4865 ex 27.

We look forward to reviewing the information you provided. Thank you!

4 of 4