Guadalupe Clinic
Volunteer Application

CATHOLIC DIOCESE OF WICHITA

Date: _____

E-Mail: _____

Name: _____ DOB: _____

Address: _____

(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____

Current Employer: _____

Your Position/Responsibilities: _____

License #: (if applicable) _____ Hours you work per week: _____

Emergency Contact: _____ Phone: _____

Please choose medical or non-medical volunteer & preferences:

☐ **Sissy Donovan's Helping Hands** ☐ **Medical Professional**

☐ Clerical Data Entry ☐ Interpreter License/Certification:

☐ Fundraising Projects ☐ Speaker's Bureau _____

☐ Newsletter ☐ Handyman

☐ Special Projects ☐ Other, specify: _____

	Mon	Tues	Wed	Thurs	Fri
What hours/days are you available?	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM

How did you learn about Guadalupe Clinic? _____

Do You have any family/friends working or volunteering at Guadalupe Clinic? ◯ Yes ◯ No if so, who? _____

Briefly state why you would like to be a Guadalupe Clinic volunteer:

_____

_____

Are you able to commit to four hours per month? ◯ Yes ◯ No

Have you ever been convicted of a felony? ◯ Yes ◯ No

Have you ever been denied bond? ◯ Yes ◯ No

Have you ever been denied a license/certificate to practice? ◯ Yes ◯ No ◯ N/A

Education/Field of Studies: _____

Do you have any special skills that would benefit our clients/clinic? Please tell us about them:

_____

_____

Hobbies/Interests: _____

_____

_____

_____

Please provide the names of two references other than family who have known you for at least five years:

Name	Phone Number	Relationship

Applicant Signature: _____ Date: _____

Charitable Health Care Provider Agreement

For Providing Care through Indigent Health Care Clinic or Other Point of Entry

Name: _____ Date of Birth: _____/____/____
First MI Last

License or Registration Number: _____ Profession (MD, RN, DDS, etc.): _____

Address: _____ County: _____
Street Address

_____ Phone Number: _____
City State Zip

Email Address: _____ Fax Number: _____

My signature on this agreement constitutes my intention to provide care to medically indigent patients. I understand that in order to be considered gratuitous, I may not charge the patient or individually submit a claim for those patients with public or private insurance. I understand that if I provide charitable care through an indigent health care clinic or local health department, they may charge uninsured patients a reasonable fee based on patients' ability to pay (discounted/sliding fee schedule), may submit claims to public or private insurance, and I may receive a fee for my services from the indigent health care clinic or local health department.

Nothing in this agreement waives my right to bill insurance or an individual patient for services provided when that care is not provided as part of my participation in the Charitable Health Care Provider Program.

I understand it is my responsibility to participate in maintaining patient records for services that I provide as a Charitable Health Care Provider and the indigent health care clinic or point of entry through which I will provide care must:

(1) determine that individuals seen as part of my participation in the Charitable Health Care Provider Program are medically indigent; and
(2) submit an annual activity report to KDHE (KAR 28-53-1).

I will be providing care through the following indigent health care clinic or point of entry:

_____
Name of Indigent Health Care Clinic or Point of Entry

I agree that failure to fulfill any of these duties will result in cancellation of the agreement by the Secretary of the Kansas Department of Health and Environment to serve as a charitable health care provider.

_____ _____
Provider Signature Date

_____ _____
Susan Mosier, MD, Secretary Date
Kansas Department of Health and Environment

If a charitable health care provider is sued by the recipient of care, they must request representation from the state in writing within 15 days after service of process or subpoena (KSA 75-6108(e)). Indigent health care clinics, their employee(s), or charitable health care providers served with a summons or petition should immediately contact the Kansas Attorney General's office at 785-296-2215.