MMAP Team Member Application

(Please note that the Michigan Medicare/Medicaid Assistance Program (MMAP) does not accept applications from insurance agents, insurance brokers, financial planners, or employees of health care providers.)

Site ID: _____

Applicant's Name: _____

Date: _____

Service County(ies): _____
Please list the counties you will serve with the PRIMARY county listed first

I. Talents

A. MMAP team position of most interest to you (*please choose just one*):

- ❑ **Counselor:** Provides counseling and education on Medicare, Medicaid, and other health insurance programs to clients that include beneficiaries and their caregivers
- ❑ **Outreach Technician:** Promotes community awareness of MMAP, its services, and volunteer opportunities
- ❑ **Administrative Assistant**: Provides administrative and program management support including data entry and other clerical duties

B. Why are you interested in working with MMAP?

_____

_____

_____

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

___ Yes ___ No *If yes, please list language(s):* _____

_____

D. Skills and Interests (Please check all that apply.)

☐ Computer/Internet
☐ Organizing/Scheduling
☐ Public speaking with large groups
☐ Public speaking with small groups
☐ Public relations/Communications
☐ Research
☐ Teaching/Training
☐ Writing
☐ Data Entry
☐ Graphic Design
☐ General Office Work
☐ Assist individuals/One-on-one direct client service
☐ Other _____

E. Experience (include paid and volunteer experience starting with the most recent)

Company/Organization: _____

Dates of service: From _____ to _____

Contact person: _____ Phone: _____

☐ Paid employee ☐ Volunteer

Company/Organization: _____

Dates of service: From _____ to _____

Contact person: _____ Phone: _____

☐ Paid employee ☐ Volunteer

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F. Availability

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

Preferred days and times:

☐ Monday	☐ Morning	☐ Afternoon	☐ Evenings
☐ Tuesday	☐ Morning	☐ Afternoon	☐ Evenings
☐ Wednesday	☐ Morning	☐ Afternoon	☐ Evenings
☐ Thursday	☐ Morning	☐ Afternoon	☐ Evenings
☐ Friday	☐ Morning	☐ Afternoon	☐ Evenings
☐ As Needed			

G. Are you licensed and able to drive an automobile? ☐ Yes ☐ No

II. Applicant's Information

A. Contact Information

Address: _____

City: _____ State: _____ Zip code: _____

Email where MMAP may contact you: _____

Home phone: _____ Cell phone: _____

B. Business/Employment Information (if currently employed)

Occupation: _____

Company/Organization: _____ Business Ph _____

Address: _____

City: _____ State: _____ Zip code: _____

Where would you prefer to receive mail/be contacted?

☐ Home ☐ Business

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C. Education

College/University (if any): _____

Degree/Major: _____

Dates attended: _____ Graduate? ☐ Yes ☐ No

High School: _____

Dates attended: _____ Graduate? ☐ Yes ☐ No

D. Emergency Contact Information

Name: _____ Relationship: _____

Home phone: _____ Other phone: _____

E. Optional Health Status Questions

Do you have any medical conditions you would like MMAP to be aware of? ☐ Yes ☐ No

If yes, please describe: _____

_____

Do you require any special accommodations? ☐ Yes ☐ No

If yes, please describe: _____

_____

F. Conflict of Interest Screening Questions

Are you affiliated with any of the following:

Insurance company, agency or broker	☐ Yes	☐ No
Financial planning service	☐ Yes	☐ No
Health insurance claims or billing service	☐ Yes	☐ No
Law firm or legal services organization	☐ Yes	☐ No
Other *(please describe)*	☐ Yes	☐ No

If you answered yes to any of the above, please explain: _____

_____

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G. Demographics

Are you under 65 years of age and receiving, or have applied for, Social Security

Disability? ☐ Yes ☐ No

Ethnicity (please check one)

- ☐ American Indian or Alaska Native
- ☐ Arab
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White, not Hispanic origin
- ☐ Other _____

III. References

Please list three references, who are not related to you.

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

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IV. Declaration and Authorization

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 training I receive as a MMAP Team Member is to provide services free of charge to Medicare beneficiaries and is not to be used for my personal monetary gain, and
- MMAP is not required to accept all applicants for placement in positions.

I give my consent for MMAP to conduct a comprehensive background check which is part of its standard screening process for all applicants. I understand that the background check will include a national and state criminal records check and an insurance license check with the state of Michigan, and may include reference checks, checks on my driving record, and checks into my employment and volunteer history and experience.

I authorize MMAP to contact the references named above with regard to my application to become a MMAP team member. I also authorize the persons referenced to provide information in connection with my application and release them from any liability in regard to it.

I understand that I do not have to agree to this background check, but that my refusal may exclude me from consideration for MMAP "positions of trust" that include a role as a counselor or, depending on job responsibilities, an administrative assistant.

I understand that MMAP will limit the information it collects to that needed to determine my suitability for particular types of team member work, that it will keep all such information confidential and destroy documents containing my Social Security number once the criminal records check is complete.

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Applicant's Signature: _____

Date:_____

Coordinators's Signature: _____

Date: _____

Applicant: *Please mail or deliver this form to your* ***local*** *MMAP office.*

Coordinator: Please keep the original for your files and fax to 517-886-1305 or mail a copy of this form to MMAP, Inc.

MMAP Mission

To educate, counsel, and empower Michigan's older adults and individuals with disabilities, and those who serve them, so that they can make informed health benefit decisions.