



MMAP, Inc.
Michigan Medicare/Medicaid Assistance Program

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.)

Applicant's Name: _____

Date: _____ **County:** _____

I. Talents

A. MMAP team position(s) of interest to you:

- Counselor:** Provides counseling and education on Medicare, Medicaid, and other health insurance programs to clients that include beneficiaries and their caregivers
- Counselor Assistant:** Provides support to counselors in their work with beneficiaries and their caregivers
- Outreach Assistant:** 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?

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.)

- | | |
|--|--|
| <input type="checkbox"/> Computer/Internet | <input type="checkbox"/> Organizing/Scheduling |
| <input type="checkbox"/> Public speaking with large groups | <input type="checkbox"/> Public speaking with small groups |
| <input type="checkbox"/> Public relations/Communications | <input type="checkbox"/> Research |
| <input type="checkbox"/> Teaching/Training | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Data Entry | <input type="checkbox"/> Graphic Design |
| <input type="checkbox"/> General Office Work | |
| <input type="checkbox"/> Assist individuals/One-on-one direct client service | |
| <input type="checkbox"/> 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

F. AvailabilityHours per week: 4 or less 5 to 10 More than 10

Preferred days and times:

- | | | | |
|------------------------------------|----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Monday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> Tuesday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> Wednesday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> Thursday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> Friday | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evenings |
| <input type="checkbox"/> 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: _____

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

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: _____

G. Criminal Background Check Screening Questions

Because some of our clients are vulnerable to financial and other exploitation, MMAP, Inc. uses the Michigan State Police background check system to screen all applicants for MMAP team member positions. We ask for the following information to ensure that the State Police background check system responds properly.

Gender: _____ Date of Birth: _____

Other name(s) you may be known as (such as a maiden name or birth name, etc.):

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: _____

IV. 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 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;
- the Michigan State Police will conduct a criminal background check as part of MMAP's standard screening process for all applicants; and
- MMAP is not required to accept all applicants for placement in positions.

Applicant's Signature: _____

Date: _____

Coordinators's Signature: _____

Date: _____

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

Coordinator: Please make a copy of this form for your files and send the **original** 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.



LOCAL HELP FOR PEOPLE WITH MEDICARE

Developed by MMAP, Inc. and the Health Assistance Partnership