ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Aging & Adult Administration • State Health Insurance Assistance Program

MEMORANDUM OF UNDERSTANDING
REGARDING VOLUNTEER COUNSELOR RESPONSIBILITIES AND OBLIGATIONS

We Thank You For Your Service!

As a Volunteer Counselor with the Arizona State Health Insurance Assistance Program (SHIP), I have read the Counselor's Job Description and agree to perform such duties in accordance with program guidelines issued by the State Coordinator or my Area Agency SHIP program Specialist. I understand that the Aging and Adult Administration, Area Agency on Aging or any other sponsoring organization is only responsible for actions and activities conducted within the scope of the program and in concert with its regulations and guidelines.

1. **Nature of Service**
   I understand that my service as a volunteer includes assessing needs of clients for information and assistance, Medicare, Medicare +Choice, Medigap, Appeals, ESRD, disability, and Long Term Care, and to counsel and assist clients in filing claims, appeals, Cost Sharing applications, disenrollment forms, and Arizona Long Term Care applications. I may be called on to provide information, counseling or assistance to Medicare beneficiaries who need assistance in understanding or filing claims with the benefits programs they have. I agree to attend training sessions as required and complete client assistance and tracking records as needed by the program.

2. **Confidentiality**
   I understand that in the performance of my duties, I may have access to detailed personal and financial information of clients. I assure the program and my clients that I will use such information only in pursuit of assisting the clients and will not divulge confidential data to external sources other than Medicare, service providers or insurance carriers in conjunction with my counseling or assistance duties.

3. **Non-Conflict of Interest**
   I understand that the program must certify that all staff members including volunteers have no conflict of interest in providing services to program clients. I agree to abide by both the letter and the spirit of maintaining con-conflict of interest by:
   a. Ensuring that I do not use or disclose client information for personal fain or advantage by other persons.
   b. Insofar as is possible, not encouraging or recommending the purchase of a specific type or company's coverage, the use of a provider for treatment or the service of a specific agent or agency.
   c. Respecting the trust and confidence my clients place in me and exercising good faith and integrity in the performance of my duties.

4. **Terms of Service**
   I understand that this Agreement is open-ended and that my hours of service will be determined mutually between myself and my coordinator. This agreement shall remain in effect until termination in writing by myself or my coordinator and that breach of the agreement is only construed as a violation of the confidentiality or non-conflict of interest sections.

_____ _____
Volunteer's Signature *Date*

_____ _____
Coordinator's Signature *Date*

_____ _____
Volunteer's Name *Date*

_____ _____
Address *Date*

_____ _____
City *State* *ZIP Code* *Telephone No.*