MMAP, Inc.
Michigan Medicare/Medicaid Assistance Program

Navigating Medicare

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?

_____

_____

_____

_____

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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: _____

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 accomodations? ☐ 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. 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 orgin

☐ 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

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.

MMAP, Inc.
Michigan Medicare/Medicaid Assistance Program

Navigating Medicare

SMP
Empowering Seniors To Prevent Healthcare Fraud

ship state health insurance assistance programs
LOCAL HELP FOR PEOPLE WITH MEDICARE

Developed by MMAP, Inc. and the Health Assistance Partnership