

Virginia Association of Healthcare Auxiliaries and Volunteers

Capital • Hampton Roads • Northern • Piedmont • Southwestern

Forms

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**Virginia Association of Healthcare Auxiliaries and Volunteers
Capital • Hampton Roads • Northern • Piedmont • Southwestern**

APPLICATION FOR MEMBERSHIP

Date: _____

Organization Name:

We hereby make application for membership in the Virginia Association of Healthcare Auxiliaries & Volunteers (VAHAV).

We understand that our membership is renewed upon payment of annual dues. Payment of \$_____ is, () enclosed or () previously submitted. Second year dues will be reduced by pro-rating the number of months remaining in your membership at the close of the fiscal year. Payment should be made to VAHAV and directed to the Membership Chair.

Name _____

Title _____

Address _____

Telephone _____

Email _____

Other:

Name _____

Title _____

Address _____

Telephone _____

Email _____

Please return a copy of this application form to the President and to the Membership Chair:

Emily Brooks
President
917 Chambers Street
South Hill, VA 23970

Brenda B. Shively
Membership Chair
414 Thompson Ridge Circle
Ferrum, VA 24088

Virginia Association of Healthcare Auxiliaries and Volunteers

Auxiliary and Volunteer Presidents Fiscal Year Dues

The Virginia Association of Healthcare Auxiliaries and Volunteers has been established as a nonprofit organization. As such, VAHAV depends upon its member auxiliaries and volunteer facilities to support the organization through its submission of yearly membership dues. These annual dues enable VAHAV to function at the State and National levels and represent your activities as described in Article 11 of the By-Laws found in Section 11 of the VAHAV Leadership Manual.

The number of adult Auxilians and Volunteers you identified and included in the Annual Survey determines the amount of dues your organization is assessed. The Base Charge varies between \$15.00 and \$80.00 based on the total number of members reported. The per-member charge is \$.35 per member. The range of the Base Charge is as follows:

Total Membership	Base Charge
1- 50	\$15.00
51- 100	30.00
101- 200	45.00
201- 400	60.00
400 or more	80.00

The approved method of computing membership dues for your organization is as follows:

_____ Members @ \$.35 per member = \$ _____

Base charge for your organization = \$ _____
()\$15, () \$30, () \$45, ()\$60, () \$80

AMOUNT DUE = \$ _____

Please return your Application for Membership along with the appropriate dues to the VAHAV treasurer and retain one (1) copy for your files.

Please call or e-mail any questions or comments you have.

Bettie Moores, Treasurer
703-280-1038
3022 Ellenwood Dr.
Fairfax, VA 22031
Email: treasurer@vahav.org



Virginia Association of Healthcare Auxiliaries and Volunteers

Directory Changes

Your Name: _____

Title: _____

President, DVS, Gift Shop, Legislative, Thrift Shop

Month __, Day __, Year __, If for President, please give ending date for term of office,

Hospital: _____

Your Mailing Preference: Home, Hospital

Your Street Address: _____

City _____

State _____, **Zip** _____

Area Code: _____, **Telephone** _____

Fax Area Code: _____, **Fax Telephone** _____

Email: _____

Send a Copy to the Communications Chairman or go to www.vahav.org and select VAHAV Directory Changes and fill out the form online. To obtain the name for the current chairman email communications@vahav.org.

SAMPLE

Hospital Auxiliary Self-Assessment Questionnaire

The following questionnaire is intended as a suggested guideline and does not imply that there is only one way of doing things. When evaluating responses to these questions, auxiliary leaders should ask if their current operating practices are effective and achieving their objectives. If not, perhaps the organization's structure and management need to be evaluated.

Name of Auxiliary: _____

Name of Hospital: _____

Name of Hospital System:
(If applicable) _____

Legal Status of Auxiliary:

Integral to hospital _____ Incorporated _____ Unincorporated _____

Is your auxiliary authorized to exist in your institution's bylaws? Yes _____ No _____

List Mission Statement of:

Hospital: _____

Hospital system (if applicable): _____

Auxiliary: _____

Hospital Auxiliary Self-Assessment Questionnaire Continued

AUXILIARY BYLAWS

YES NO

- Does the mission statement in your bylaws support the overall mission of:
- Your hospital? _____
 - Your hospital system? _____
 - Do your bylaws recognize the auxiliary's accountability to your institution? _____
 - Do your bylaws define:
 - A. Structure of officers, board members and membership? _____
 - B. The length of terms of office? _____
 - C. The number of successive terms that officers may serve? _____
 - D. The duties, responsibility and authority of officers? _____
 - E. A membership policy? _____
 - F. The authority to create and terminate standing and ad hoc committees? _____
 - G. Establishment of operating policies and procedures? _____

POLICIES AND PROCEDURES

- Do you have written policies and procedures to cover:
- A. Guidelines for officers, board members and committee chairmen? _____
 - B. Recruitment and retention of members? _____
 - C. Orientation of new members? _____
 - D. Orientation for board members? _____
 - E. Continuing education for all members? _____
 - F. A formal recognition/awards program? _____
- Do you keep your membership informed of auxiliary and hospital activities? _____
 If so, how? Newsletter ___ Letters ___ Other ___
- Do you evaluate your objectives to see if they have been met? _____
- Do you evaluate the effectiveness of your program annually? _____
- Do you have:
- Short Range goals with procedures in place for meeting them? _____
 - Long Range goals with procedures in place for meeting them? _____
- Do you prepare an Annual Report? _____
- Do you have an established procedure for distribution of the Annual Report? _____
- To: Membership _____
- Medical Staff and Employees _____
- Administration _____
- VAHA District Chairman _____
- Governing Board _____

FINANCIAL MANAGEMENT

- Do you have a Finance Committee? _____
- Do you maintain two budgets, i.e.,
1. Operating Budget, based on dues, donor restricted funds and fees? _____
 2. Financial Contributions Budget, based on net earnings from income producing activities? _____

Hospital Auxiliary Self-Assessment Questionnaire Continued

- Are your budgets reviewed periodically during the year? _____
- Are budgetary actions properly recorded in your minutes? _____
- Do you analyze the cost of each fund raising activity? _____
- Do you maintain accurate records of all fund raising activities? _____
- Do you adhere to all federal, state and local regulations in fund raising? _____
- Are your books audited annually? _____
- If so, by whom? Hospital _____
- Independent Auditor _____
- Other _____
- Is your annual financial statement part of the auxiliary annual report? _____

RECORDS

- Do you have an established system for filing and storing permanent records? _____
- Is a specific person responsible for supervising these records? _____
- Do you have a time limit for retention of records and reports not classified as permanent? _____
- Do you retain at least one copy of all minutes in your permanent file? _____
- Do you keep seven years of financial records on file? _____

COMMUNITY RELATIONS

- Are the overall community relations goals of the auxiliary consistent with the goals of your institution's governing body? _____
- Do you have specifically stated written objectives that demonstrate the auxiliary's role in community relations? _____
- Is your auxiliary now serving as an effective liaison between the hospital and the community? _____
- Do you help the hospital identify the needs of the community? _____
- Do you help the community understand the services provided by the hospital? _____
- Do you help the community understand the issues facing the hospital? _____

VAHA

- Do you have an updated VAHAV Leadership Manual? _____
- Do you prepare an annual survey for VAHAV? _____
- Do you submit news to the VAHAV Connection? _____
- Do you notify your district chairman when there is a change in presidents? _____

A detailed Self-Assessment Questionnaire for the Hospital Auxiliary may be ordered from the American Hospital Association, Catalog #019120. Cost for member - \$36.00 plus handling, non-member - \$39.00 plus handling. To order write AHA Services, Inc., P.O. Box 92683, Chicago, IL 60675-2683 or call toll free: 1-800-AHA-2626.

SAMPLE

Memorandum Of Understanding

This memorandum of Understanding is made and entered into this _____ day of _____, 20____, by and between the Auxiliary, hereinafter referred to as "Auxiliary" and _____, hereinafter referred to as "Vendor".

The Auxiliary is a service organization associated with _____ Hospital , _____, Virginia, and the Vendor from _____, sells certain items of personal property clearly defined as follows:

_____.

The Auxiliary and Vendor agree that the sale of the Vendor's items, as listed above, is to be conducted at _____ Hospital on the _____ day of _____, 20____, beginning at _____ a.m./p.m. and ending at _____ a.m./p.m. The Vendor will be allowed to set up the items at _____ a.m./p.m. on the _____ day of _____, 20____, prior to the sale and dismantle by _____ a.m./p.m. on the _____ day of _____, 20____, after the sale.

The Vendor agrees to pay the Auxiliary _____ percent (_____ %) of the gross receipts of said sale. Either party may terminate Memorandum of Understanding giving (_____) days notice in writing of their intention to cancel and Memorandum of Understanding will be null and void.

(Name) -Authorized Auxiliary Representative (Seal)

_____ Auxiliary

_____ President

_____ (Seal)

(Name) -Authorized Vendor Representative

VAHAV Skills Bank

HOPITAL _____ VAHAV DISTRICT: _____

NAME: _____ PHONE _____

HOME ADDRESS: _____

CURRENT OFFICE AND/OR SERVICE WORK _____

PAST ORGANIZATIONAL EXPERIENCE & EXPERTISE _____

FAMILY _____

HOME & COMMUNITY INTERESTS _____

HOBBIES, TALELNTS & EXPERTISE _____

REMEMBER PLEASE: AUXILIANS AND THEIR ORGANIZATION CONTINUE TO GROW THROUGH EXPERIENCE AND INVOLVEMENT!!!

1. WOULD YOU BE WILLING TO SHARE YOUR EXPERIENCE/EXPERTISE AT A STATE MEETING? YES ___ NO ___
IF YES, WITH A LARGE GROUP? _____ WORKSHOP? _____ DISTRICT MEETING? _____
2. WOULD YOU CONSIDER A POSITION ON THE:
VAHAV DISTRICT BOARD? YES ___ NO ___ VAHAV BOARD OF DIRECTORS? YES ___ NO ___

MY SPECIAL INTEREST IS _____ COMMITTEE.

COMMENTS: _____

COMMENTS CONTNUED _____

PLEASE RETURN THIS FORM TO:
ONE COPY TO: VAHAV PRESIDENT
ONE COPY TO: DISTRICT CHAIRMAN

SIGNED: _____

DATED: _____

Virginia Association of Healthcare Auxiliaries and Volunteers

Sponsor/Contributor Contract Annual Conference

Conference Location _____

Conference Address _____

Name of Sponsor: _____

Address: _____

City, State and Zip: _____

Telephone: _____ FAX: _____

E-Mail: _____

Contact Person: _____

Sponsor's/Contributor's Authorized Signature:

_____ Date _____

Event Sponsored: _____

Donation Amount: _____

- All Sponsors/Contributors will have posted recognition in the Registration Area assigned for the Conference.
- Sponsor's/Contributor's name will be displayed at the Banquet on Monday night, the Luncheon on Tuesday and the closing Breakfast on Wednesday.
- IF sponsoring a speaker for the VAHAV Conference, the name of the sponsor will be displayed in the area designated for that event.
- All sponsors and contributors will be listed in the program book that will be distributed to all attendees.
- All sponsors and contributors will be listed in the VAHAV October Newsletter,

VAHAV Corporate Sponsor Signature

Address: _____

City, State, Zip: _____

Phone: _____

Email: CorporateSponsor@vahav.org _____

Date: _____