



**Matter of Balance: Managing Concerns About Falls  
Coach Application**

**Date:** \_\_\_\_\_ **Birthday (month & day):** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Best way to contact me:** \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Gender:**  female  male

**Age group:**  Less than 50 yrs  50-54 yrs  55-59 yrs  
 60- 64 yrs  65 – 69 yrs  70 – 74 yrs  
 75 – 79 yrs  80 – 85 yrs  Over 85 yrs

**Education:**

- |  |   |
|--|---|
| <input type="checkbox"/> Some high school                  | <input type="checkbox"/> High school graduate |
| <input type="checkbox"/> Some college or vocational school | <input type="checkbox"/> College graduate     |
| <input type="checkbox"/> Some graduate school              | <input type="checkbox"/> Graduate school      |

**Occupation or life experience:** \_\_\_\_\_

\_\_\_\_\_

**Hobbies and activities enjoyed:** \_\_\_\_\_

\_\_\_\_\_

**Other volunteer experiences:** \_\_\_\_\_

**Do you speak more than one language?**       Yes     No

**If yes, what language(s):** \_\_\_\_\_

**Do you have transportation?**       Yes     No

**How did you hear about a Matter of Balance?**

Flyer     Newspaper     Word of mouth     Presentation

Other \_\_\_\_\_

**Why are you interested in becoming a Matter of Balance coach?**

\_\_\_\_\_  
\_\_\_\_\_

**My Basic Availability:**

I would be available for sessions held:

Monday + Wednesday     Tuesday + Thursday

Wednesday + Friday

Best time of day: (2 hour sessions)

Mornings     Afternoons

Not sure- please call me when you are scheduling a class

**Additional Comments:**

**SEE NEXT PAGE FOR MEMORANDUM OF AGREEMENT**

**THANK YOU!**



## Memorandum of Agreement

To ensure the quality of A Matter of Balance Program (MOB), the following policies and procedures have been instituted. Please sign below, along with your employer indicating your acknowledgement and acceptance of these requirements.

1. I understand that MOB Coach Trainings and Matter of Balance Programs must be held in facilities that are physically accessible to the disabled, which have meeting rooms that are safe and comfortable.
2. I understand that the meeting facility or sponsoring organization must have adequate insurance coverage for the MOB Coach Trainings and MOB programs.
3. I understand that the MOB Coach Training Workshop is open only to those who have been pre-screened and approved. All applicants must complete this application form and receive a confirmation letter before being eligible to attend a MOB Coach Training Workshop. Walk-ins will not be allowed into the Coach Training Workshop.
4. I understand once I have completed the coach training workshop I will be eligible to teach the program in the community. I also understand that only approved **master** trainers can teach others how to be MOB Coaches. Only persons who have successfully completed the master training workshop conducted by trainers approved by MaineHealth's Partnership for Healthy Aging are eligible to be master trainers.
5. I agree to conduct the program in accordance with the program guidelines and agree not to change the program in any way without prior written authorization from the Polk County Health Department.
6. I understand that I will not receive payment from the MOB participants for teaching the Matter of Balance Program.
7. I understand that once I have lead and completed the twice a week for 4 week sessions, the Polk County Health Department may provide a small honorarium.
8. I agree to complete or schedule my **first** four-week program by the end of **March 31, 2010** and my **second** four-week program by the end of **September 30, 2010**.
9. I understand that my certification as a MOB coach will become invalid if I do not teach a minimum of two MOB four-week programs each year (**October 1, 2009 through September 30, 2010**).
10. I agree to teach ALL MOB programs with a co-leader.
11. I agree to coordinate with the Polk County Health Department recruitment of participants and MOB workshop sites.
12. I understand that I am implementing the MOB under the Polk County Health Department license, obtained from by MaineHealth's Partnership for Healthy Aging. Neither my employer, if applicable, nor I will be required to pay a MOB license fee to MaineHealth's Partnership for Healthy Aging as long as the MOB workshops are coordinated through the Polk County Health Department.
13. I agree to keep the Polk County Health Department informed of my current contact information.
14. I agree to return all completed paperwork (Attendance Sheet, Consent Forms, First/Last Class Surveys and Class Evaluations) to the Polk County Health Department at the completion of each four week program.

15. The Polk County Health Department agrees to provide all teaching materials at no charge.

16. The Polk County Health Department agrees to keep a database of coaches and conduct conference calls, send emails, and/or U.S. mail notifications when information regarding the MOB needs to be communicated.

17. The Polk County Health Department agrees to all provide technical assistance for the MOB.

18. I assure that all paperwork (Attendance Sheet, Consent Forms, First/Last Class Surveys and Class Evaluations) will be completed and returned to the Polk County Health Department at the completion of each four week program.

**Participant Signature:**

Print Name:

**Date:**

**Participant's Employer Signature:**

Print Name:

**Date:**

**Polk County Health Department**

**Representative Signature:**

Print Name:

**Date:**

Revised: August 2009