



**A 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 (if applicable) 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 or once a week, 8 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 **February 29, 2012** and my **second** four-week program by the end of **August 31, 2012**.
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 (**September 1, 2011 through August 31, 2012**).
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. The Polk County Health Department agrees to provide all teaching materials at no charge.

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

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

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

Participant Signature:

Print Name:

Date:

Participant's Employer Signature:

Print Name:

Date:

Polk County Health Department

Representative Signature:

Print Name:

Date:

Revised: February 2011