MEMORANDUM OF UNDERSTANDING
REGARDING
COUNSELOR RESPONSIBILITIES AND OBLIGATIONS

Name of Counselor		Date
Address		
City	Zip	Telephone Number
e- mail address (if any)		Fax Number (if any)

As a Counselor in the Colorado Senior Health Insurance Assistance Program, I agree to abide by all program guidelines and regulations. Neither the Colorado Senior Health Insurance Assistance Program nor the regional sponsoring organization is responsible for activities other than those stated in these program guidelines. Any action beyond those covered in the guidelines will be taken at my personal risk.

1. **Nature of Service**

I understand that my basic responsibilities as a counselor include 1) providing accurate and objective information, counseling, and assistance about Medicare and related health insurance coverage to Medicare beneficiaries, their representatives, or persons soon to be eligible for Medicare, and 2) educating the public on Medicare and health insurance issues that affect people on Medicare. I agree to undertake initial training and continuing refresher training as required under this program. I understand that my counseling of older adults and disabled Medicare beneficiaries may need to be accomplished at specified counseling sites, by telephone, or at clients' homes if required by their health conditions. I agree to complete specified client report forms and public and media activity forms and submit these reports to my regional coordinator.

2. **Confidentiality**

It is understood that in the performance of my duties, I will have access to certain sensitive information about the client including medical, insurance, financial and other personal and confidential data. I agree to restrict my use of such information to the performance of duties described in the

program guidelines and understand that such information shall be kept private except as necessary to perform counselor functions.

3. **Non-Conflict of Interest**

The Colorado Senior Health Insurance Assistance Program requires that Counselors shall not promote private or personal interests in conjunction with the performance of duties outlined in this memorandum of understanding. To comply with these requirements, I agree to the following:

A. I will in no way attempt to conduct market research or solicit, persuade or coerce clients to purchase a specific type of medical insurance coverage; to persuade clients to use a specific healthcare provider; to direct a client to a specific agent/broker; or to direct a client to any specific profit-based billing service.

B. I will not disclose or use confidential information obtained as a result of my access to any client through the Colorado Senior Health Insurance Assistance Program for personal gain or advantage for my employer or any other party.

C. I acknowledge my obligation to exercise good faith and integrity in the performance of my duties as a Counselor in the Colorado Senior Health Insurance Assistance Program. I understand that a breach of this agreement may result in my release from the program and subject me to liability for these violations or actions taken in the name of the program that are outside the scope of the program.

My signature denotes that I have read and understand this memorandum of understanding.

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Counselor Signature Date