



Resident Advocate Reference

Date: _____ **Volunteer Name:** _____

Reference: _____ **Phone:** _____

Address: _____

Length of time known: _____

In what capacity: _____

Strengths individual would bring to volunteer experience: _____

Are there any reservations you would have about the individual in the described volunteer experience?

Overall Comments: _____

Reference Signature: _____

Reference Contact Date: _____

Please Return To:

VRA/Ref6/-12/5/2018

State Ombudsman/ Mairead Painter
State Long Term Care Ombudsman Program
ADS/State Unit On Aging
Email LTCOP@ct.gov