



Community Action Partnership of Mid-Nebraska

VOLUNTEER SERVICE RECORD

NAME	DATE	HOURS	SUPERVISOR SIGNATURE

Site Supervisor
Community Action Partnership of Mid Nebraska

RELEASE OF INFORMATION

I understand that as a condition of my employment, my name will be checked against the Nebraska Department of Health and Human Services Adult/Child Protective Services Central Registers. A check of these registers is necessary to ensure that I meet provider standards.

The purpose of this check will be to determine if my name is being maintained on either register as a result of previous abuse/neglect allegations which have been investigated and have not been determined to be unfounded.

To the best of my knowledge, I do not have a conviction or prior history of adult or child abuse/neglect or maltreatment. Neither have I been convicted of a crime involving moral turpitude.

I hereby authorize the Nebraska Department of Health and Human Services to release information contained on the Adult or Child Protective Services Central Register including the information that a record has been found to:

Community Action Partnership of Mid-Nebraska
(Agency/Facility Requesting Check)

16 W. 11th, Kearney, NE 68845
(Address – Street, City, Zip)

FAX number for facility 308-865-5681

(Signature of Applicant/Employee)

(Date Signed)

(Printed or Typed Name of Applicant/Employee)

(Social Security Number)

Other Names Used in Past Twenty (20) Years
(Please Print or Type)
(Use back of sheet if necessary)

Other Addresses in Past Twenty (20) Years
(Please Print or Type)
(Use back of sheet if necessary)

Names of Children Who Have Lived With You
(Please Print or Type)
(Use back of sheet if necessary)

(Date of Applicant's Birth)

(Home Address of Applicant /City/Zip)

(Witness Signature)

(Date Witnessed)



Community Action Partnership of Mid-Nebraska
16 W. 11th Street – P.O. Box 2288 – Kearney, NE 68848-2288

Confidentiality Agreement

Confidentiality of client information is a fundamental individual right upheld by Community Action Partnership of Mid-Nebraska Programs. All volunteers are expected to protect client confidentiality, privacy and security.

Volunteers may have access to confidential information including, but not limited to:

- Client's personal information
- Identifying client demographic information such as name, address, phone etc.
- Information about program staff

Privacy, Confidentiality, and Security definitions:

- **Privacy** refers to the right of individuals to keep information about them from being disclosed to anyone.
- **Confidentiality** means we have an obligation to prevent others from accessing information about families without their permission.
- **Security** means we control access to paper or computer files, which contain private information.

The premise for client information confidentiality, privacy and confidentiality is based on two beliefs:

1. Individuals have a fundamental right to control the disclosure and use of information about themselves.
2. Information about an individual, revealed to some other party not willingly designated by the individual, may be used to harm his or her interests.

Client's confidential and private information may come directly from a client and/or family/caregiver interview, the paper client record or the computerized client record.

In order to protect client confidentiality, privacy and security **volunteers must:**

1. Prevent unauthorized use of any information in files maintained, stored or processed by Community Action Partnership of Mid-Nebraska Programs. Not exhibit, divulge, or share the contents of any record or report except to fulfill a work assignment in accordance with Community Action Partnership of Mid-Nebraska Programs.

2. Report any violation of confidentiality, privacy and security by any staff member, volunteer, student, or interpreter/translator.
3. Understand that the information accessed through all clinical information systems contains sensitive and confidential client, agency and employee information that should only be disclosed to those authorized to receive it.
4. Not divulge or share any information that identifies a client or health care provider.

Volunteers agree to:

1. *Respect the privacy and rules* governing the use of any information accessible through the computer system of network and only utilize information necessary for client care and clinical learning assignments.
2. *Prevent unauthorized use* of any information in files maintained, stored or processed by Community Action Partnership of Mid-Nebraska.
3. *Not share*, exhibit or divulge the contents of any record or report except to fulfill a work assignment in accordance with Community Action Partnership of Mid-Nebraska's Programs.
4. *Not knowingly* include or cause to be included in any record or report, a false, inaccurate, or misleading entry.
5. *Not remove any record* (or copy) or report from the Community Action Partnership of Mid-Nebraska where it is kept except in the performance of normal daily duties.
6. *Report a violation* of confidentiality, privacy and security.
7. *Understand* that the information accessed through all clinical information systems agencies contains sensitive and confidential client, agency and employee information that should only be disclosed to those authorized to receive it.

Respect the confidentiality of any reports printed from any information system containing client/member information and handle, store and dispose of these reports appropriately at the associated clinical agency.

8. *Not divulge any information* that identifies a client/care provider.
9. *Understand* that all access to information concerning the client's information will be monitored.

I agree to follow all rules and regulations of Community Action Partnership of Mid-Nebraska confidentiality practices.

Signature

Date



Community Action Partnership of Mid-Nebraska Volunteer Agreement

I _____, hereby agree to perform volunteer work for Community Action Partnership of Mid-Nebraska. I understand that I will not be paid for my services.

I also understand that I will not be covered by Workers Compensation or Unemployment Insurance under Community Action Partnership of Mid-Nebraska due to the fact that I am volunteering and not considered an employee of the agency.

Volunteer

Date

Verifying Supervisor

Date



Community Action Partnership of Mid-Nebraska Volunteer Application

C/S, UNK, KPS, Other
hours needed _____
Restrictions Y N

Name: _____ Phone (H) : _____ (w): _____

(May we call you at work _Yes _ No)

Address: _____ Email: _____

Social Security Number For RSVP/Compassionate Connections: _ _ _ - _ _ - _ _ _ _

Occupation: _____ Date of Birth _____

Ethnic Group :(optional) ___ Caucasian ___ African American ___ Hispanic ___ Native American/Alaskan ___ Asian, Pacific Islander ___ other

Volunteer options:

- | | | |
|---------------------------|------------------------|------------------------------|
| ___ friendly visits | ___ yard work | ___ shopping/errands |
| ___ escort/transportation | ___ light housework | ___ writing letters/reading |
| ___ respite care | ___ minor home repairs | ___ telephone reassurance |
| ___ meals during recovery | ___ office help | ___ other: _____ |
| ___ food bank/ware house | ___ children/youth | ___ special community events |

Placement preference:

Please check all that apply:

I can volunteer: ___ once a week ___ more than once a week ___ as needed ___ other

Time/Day	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun
Morning							
Afternoon							
Evening							

Matching information:

General interests, skills, volunteer experience, languages, and hobbies: _____

Do you smoke? ___yes ___no

Are you allergic to pets? ___yes ___no

List any special considerations for your placement (distance from home, preference for age or gender of care receiver)? _____

Consent for use of Pictures taken of Volunteers for Recognition and Publicity Yes No

Screening information:

Do you have a valid driver's license? (only if transporting individuals) ___yes ___no

License number: _____

Insurance company: _____ Policy number: _____

Have you ever been convicted for violation of any laws, traffic or otherwise? ___yes ___no

If yes, please explain: _____

Name of Probation Officer and phone number: _____

Do you have any physical limitations that may limit your volunteer activities? ___yes ___no

If yes, please describe: _____

Emergency contact:

Name: _____ Phone: _____ Relation: _____

References:

Please list two persons we may contact who are not family members. You may include employers, teachers, religious leaders, or others whose relationship to you is more than a personal friend, and over 18 years of age.

Name: _____ Phone: _____ Relation: _____

Address: _____

Name: _____ Phone: _____ Relation: _____

Address: _____

Signature of Applicant

Date

Beneficiary for RSVP Supplemental Accident Insurance: Only for RSVP volunteers

Name _____ Relationship _____

Address _____ Phone _____

Area Assigned: RSVP, Head Start, CSFP, RAFT, Beads in a Box, CARE, RYDE, Community Services, Events, Other: _____