

# ARISE

## MH CLINIC INTERNSHIP APPLICATION

We consider individuals for all volunteer opportunities without regard to race, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status.

**PLEASE PRINT**

Opportunities Applied For \_\_\_\_\_ Date: \_\_\_\_\_

How did you learn about us?

- Advertisement       Relative       Inquiry  
 Employment Agency       Friend       S.U. School of Social Work       Other

Last Name	First Name	MI
Address	Number	Street
		City
		State
		Zip Code
Telephone Number(s)	Alternate Phone Number(s)	
Email address		

Why are you interested in completing your internship with ARISE?  
 \_\_\_\_\_  
 \_\_\_\_\_

Best time to contact you is: \_\_\_\_\_: \_\_\_\_ am/pm

If you are under 18 years of age, can you provide required proof of your eligibility to do volunteer work?       Yes       No

Have you ever filed an application with us before?       Yes       No  
 If Yes, give date \_\_\_\_\_

Have you ever been employed with us?       Yes       No  
 If Yes, give dates \_\_\_\_\_

Do any of your friends or relatives work or volunteer here?       Yes       No

Are you currently employed?       Yes       No  
 If yes, may we contact your present employer for references?       Yes       No

Have you ever been convicted of a misdemeanor or felony?       Yes       No  
 Are there any criminal charges pending against you?       Yes       No

Have you ever been the subject of an indicated report of child abuse, neglect or maltreatment?       Yes       No  
 If yes, was it a founded case?       Yes       No  
 If yes, was your record expunged?       Yes       No

**Please list three (3) professional or personal references that we may contact in consideration for any volunteer opportunities:**

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_

**Please describe any special skills, training, or experience you may have:**

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# **ARISE MH CLINIC Intern Applicant's Statement**

I certify that answers given herein are true and complete. I authorize investigation of all statements contained in this application for volunteering as may be necessary in arriving at a decision to utilize my volunteer services. This application to perform services as an intern shall be considered active for a period of time not to exceed twelve months.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any internship and/or volunteer relationship with this organization is of an *at will* nature, which means that the Intern / Volunteer may resign at any time and the Agency may release Intern / Volunteer at any time with or without cause. It is further understood that this "at will" volunteer relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

If I am applying to volunteer with consumers with whom I will have regular and substantial unsupervised, unrestricted physical contact, I understand that I must comply with OMH regulations and provide information and sign consent forms per NYS Mental Hygiene Law Section 31.35 and NYS Executive Law Section 845-b, present photo identification, and submit to being fingerprinted. If I am to volunteer in a similar capacity with consumers under the age of 18 years, I understand that I must complete a "State Central Register Database Check" form which will be submitted to the New York State Office of Children and Family Services to determine whether I have ever been the subject of an indicated case of child abuse or maltreatment.

Because this agency provides services to clients and consumers, and subsequently bills Medicaid for services provided in an aggregate amount that exceeds \$5 million annually, each person, as well as each employee, will be subject to periodic exclusion checks to verify that all employees have not been excluded from federal healthcare programs. An exclusion check is a search of the following databases to determine if the individual's name appears on any list:

- U. S. Department of Health and Human Services, Office of Inspector General (OIG)'s List of Excluded Individuals and Entities (LEIE) available on the website at <http://oig.hhs.gov/fraud/exclusions.html>
- The General Services Administration (GSA)'s Excluded Parties List System available on the GSA website at <http://www.epls.gov/>
- NYS Medicaid Fraud Database available on the NYS Department of Health website at [http://www.omig.state.ny.us/data/component/option.com\\_physiciandirectory/](http://www.omig.state.ny.us/data/component/option.com_physiciandirectory/)
- Office of Foreign Assets Control (OFAC) – Specially Designated Nationals (SDN) <http://www.ustreas.gov/offices/enforcement/ofac/sdn/index.shtml>

I understand that false or misleading information given in my application or interview(s) may result in dismissal from volunteer service. I understand also that I am required to abide by the rules and regulations, policies and procedures of ARISE.

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Signature of Volunteer Applicant

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Date

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Please Print Name

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Social Security Number