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**VOLUNTEER APPLICATION**

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| **We consider applicants for all positions without regard to race, religion, creed, gender, age, disability, marital or veteran status, sexual orientation or any other legally protected status.** |
|  |
| Position Applied For: |  | Date: |  |
| How did you learn about us?[ ]  Advertisement [ ]  Relative [ ]  Inquiry [ ]  Employment Agency [ ]  Friend[ ]  SU School of Social Work |
| [ ]  Other (please specify):  |  |
|  |
| APPLICANT INFORMATION (Please Print) |
| Last Name: |  | First Name: |  | MI: |  |
| Street Address: |  |
| Apt/Unit # |  | City: |  | State: |  | Zip: |  |
| Phone: |  | Alternate Phone: |  |
| E-mail Address: |  |
| Best time to contact you (AM/PM): |  |
| Date available to volunteer: |  |
|  |  |
| 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?*If yes, please list date:* \_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Yes | [ ] No |
| Have you ever been employed with us?*If yes, please list date:* \_\_\_\_\_\_\_\_\_\_\_\_  | [ ] Yes | [ ] No |
| 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 |

# References

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

|  |
| --- |
| **Reference #1** |
| Name: |  | Phone Number: |  |
| Business Name: |  |
| Business Address: |  |
| **Reference #2** |
| Name: |  | Phone Number: |  |
| Business Name: |  |
| Business Address: |  |
| **Reference #3** |
| Name: |  | Phone Number: |  |
| Business Name: |  |
| Business Address: |  |

Why are you interested in volunteering with ARISE?

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

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**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 volunteer services shall be considered active for a period of time not to exceed six months.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any volunteer relationship with this organization is an ***at will*** nature, which means that the Volunteer may resign at any time and the Agency may release 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 individuals with whom I will have regular and substantial unsupervised, unrestricted physical contact, I understand that I must present photo identification, and submit to being fingerprinted. If I am to volunteer in a similar capacity with individuals under age 18, 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 individuals, and subsequently bills Medicaid for services provided in an aggregate amount that exceeds $50,000 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%2Ccom_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 discharge. I understand also that I am required to abide by all rules and regulations of the agency.

|  |  |  |
| --- | --- | --- |
| Have you ever been the subject of an indicated report of child abuse, neglect or maltreatment?  | [ ]  Yes | [ ]  No |
| If yes, was it “indicated” or “unfounded” | [ ]  Indicated | [ ]  Unfounded |
| If yes, was your record expunged? | [ ]  Yes | [ ]  No |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Date |
|  |  |  |
| Print Name |  | Date of Birth (MM/DD/YYYY) |

**ARISE Confidentiality Statement**

I shall respect the privacy concerns of the people served by ARISE, and shall hold in confidence all information obtained in the course of professional service, whether that information is obtained through written records or daily interaction with the person and/or persons served. Therefore, I will not disclose an individual's confidential information to anyone, except:

1. to prevent clear and immediate danger to a person or persons;
2. when I am compelled to do so by a court or pursuant to the rules of a court;
3. as mandated by law.

I shall possess a professional attitude that upholds confidentiality toward the people we serve, colleagues, applicants and any situations that occur within ARISE. I shall store and/or dispose of professional records in ways that maintain confidentiality.

In addition, I understand that New York State Public Health law Article 27-F strictly prohibits the disclosure of the following types of information without the written consent of the individual:

1. information indicating that a person has been tested for HIV and/or AIDS;
2. information that a person has an HIV infection or AIDS, or is being treated for same;
3. information that would suggest a person has been or may have been exposed to HIV and/or AIDS.

I, upon completion of my volunteer service, shall maintain individual and co­worker confidentiality and l shall hold confidential any information about sensitive situations within ARISE.

I understand that all information pertaining to ARISE, its employees, Board of Directors and individuals/clients is strictly confidential. Any release of confidential information without prior approval from the Executive Director is prohibited; and may result in disciplinary action up to and including termination of internship or volunteer service. In addition, according to New York State law, any unauthorized disclosure of HIV and/or AIDS protected health information under Article 27-F is a violation of state law and may result in a fine or jail sentence or both.

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Signature of volunteer Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please PRINT your name

ARISE Child & Family Service

EMERGENCY CONTACT

I, as an employee of ARISE Child & Family Service, understand that during the course of my employment with the Agency an emergency may arise. In the event of such an emergency, I authorize the Agency to contact the following on my behalf.

My home phone number:

1.

 Name

 Address

 Home Phone Work Phone

 Relationship

1.

 Name

 Address

 Home Phone Work Phone

 Relationship

Signature

Date