Quality Behavioral Health
900 7th Street, Clarkston, Washington 99403
(509) 758-3341
(509) 769-6057 HR fax
www.qualitybehavioralhealth.com

quality behavioral health

Application to Intern/Volunteer

PLEASE MARK DOWN WHICH PROGRAM YOU ARE INTERESTED IN

Adult Mental Health Program_____ **Chemical Dependency Program** _____
Child Mental Health Program _____ **Community Sexual Assault Program** _____
Summer Youth Program_____

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: **( )** E-mail Address:

Date Available: Social Security No.:

Have you ever worked or volunteered for this company? YES ☐ NO ☐ If yes, when?

Background Inquiry Statement

Quality Behavioral Health is directly responsible to provide services and treatment to children, adolescent, vulnerable adults, and persons who are chemically dependent and or mentally ill. As a result of contact with this special population whether or not contact with this group is direct or incidental, all employees/volunteers may be subject to a background inquiry of civil adjudications, conviction records or crimes against persons, final professional board disciplinary decisions, and eligibility to participate in federal healthcare programs in accordance with RCW43.43.830-845 and 42 CFR 438.610. Information will be verified through the Washington State Patrol and/or local law enforcement, the Central registry of Child Abuse and Neglect, and the Washington Department of Health, US Health and Human Services and Excluded Parties Listing System. A background inquiry is conducted as a condition of employment (including volunteer positions) and periodically throughout employment. Certain information may result in denial of employment or dismissal if actively employed.

Has your name been placed on a registry or required to be placed on a registry of child or adult abuse in Washington State, any other state, or any international location? YES ☐ NO ☐ If yes, explain:

Have you been found to have sexually abused, exploited, or physically abused a child or adult? YES ☐ NO ☐

A. in a court action / proceeding? YES ☐ NO ☐
B. By a professional disciplinary board or agency? YES ☐ NO ☐
If yes, to either question, explain:

Have you ever been convicted of a felony? YES ☐ NO ☐ If yes, explain:

By signing or typing my name below in the signature line, I understand that I may be asked to give written consent and be subject to a background inquiry upon accepting a volunteer position and periodically throughout the period of my volunteer work. I certify that my responses to the questions above are true and complete to the best of knowledge.

Signature:_____Date:_____

List all other names which you have used in employment, as a volunteer, or in your education?

Education

High School: Address:

From: To: Did you graduate? YES ☐ NO ☐ Degree:

College: Address:

From: To: Did you graduate? YES ☐ NO ☐ Degree:

Other: Address:

From: To: Did you graduate? YES ☐ NO ☐ Degree:

References

Please list three references.

Full Name: Relationship:

Company: Phone: **( )**

Address:

Full Name: Relationship:

Company: Phone: **( )**

Address:

Full Name: Relationship:

Company: Phone: **( )**

Address:

Previous Employment an Volunteer Experience (please include all whether paid or unpaid)

Company: Phone: **( )**

Address: Supervisor:

Job Title: Starting Salary: **$** Ending Salary: **$**

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: Phone: **( )**

Address: Supervisor:

Job Title: Starting Salary: **$** Ending Salary: **$**

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: Phone: **( )**

Address: Supervisor:

Job Title: Starting Salary: **$** Ending Salary: **$**

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Military Service

Branch: From: To:

Rank at Discharge: Type of Discharge:

If other than honorable, explain:

Disclaimer and Signature

I certify that the information I have provided on this application and all attached documents are true and complete to the best of my knowledge and that it contains no willful misrepresentations or falsification. I understand that the discovery of any misrepresentation or falsification may result in the rejection of my application or end my volunteer position. I give my authorization to Quality Behavioral Health (QBH) to thoroughly verify the information provided on this application and all attached documents. I release all persons, companies, and organizations from liability in providing or receiving this information. I also understand that as a condition of volunteering, I may be subject to background inquiry, verification of eligibility to participate in a federal health care program, evidence of drivers license or State issued identification card and in some instances driving history inquiry and proof of liability insurance when operating a vehicle or your own vehicle of QBHS business. I understand that the result of such inquiry may preclude me from this or future volunteer opportunities or if this application leads to placement as a volunteer may result in my release.

Signature: _____ Date: _____

APPLICANTS VOLUNTARY EQUAL OPPORTUNITY SELF-IDENTIFICATION FORM

Quality Behavioral Health services (QBH) provides equal employment opportunity (EEO) to all persons whether employed or working as a volunteer without regard to race, ethnic background, gender, disability or as a veteran of the Vietnam or any other era.

In order to comply with recordkeeping requirements for our EEO programs you are invited to self-identify. You may complete this information or choose not to. You choice not to participate in voluntary self-identification as well as any information that you do choose to provide will be kept separate from your volunteer application and will not be used in any way as a part of our placement decision.

Please complete the top section of this form even if you prefer not to complete the self-identification section.

Thank you for your assistance.

Full Name: _____ Date: _____

Last *First* *M.I.*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Position Applied for:

No thank you. I choose not to participate in voluntary self-identification, below.

VOLUNTARY SELF-IDENTICATION

VETERAN STATUS.

Are you a Veteran of any US Military service? YES ☐ NO ☐ Are you a Vietnam Era Veteran? YES ☐ NO ☐

ETHNICITY.

Please indicate which ethnicity you consider yourself?

☐ Black ☐ Native American ☐ Hispanic ☐ Other _____ ☐ Asian / Pacific Islander ☐ White (non-Hispanic)

DISABILITY.

Do you wish to identify yourself as a person with a disability?

☐ Disabled ☐ Not Disabled

ACCOMODATION.

Do you require an accommodation to perform the essential duties of the job for which you have applied? *Accommodation does not disqualify you from employment*

☐ I do not require accommodation
☐ I require accommodation

Certified Background Services
Nationwide Criminal & Sex Offender Search

A COMPLETE & CONCISE CRIMINAL RECORD REPORT

Our 50 State Criminal History Search is generated using Federal, State and County database containing over 1.2 billion criminal records which are 100% accurate, reliable and updated daily for a complete comprehensive report containing all arrests and convictions including felony, misdemeanor and sexual offenders/predators.

REQUESTING AGENCY/ADDRESS

Quality Behavioral Health
900 7th Street
Clarkston, WA 99403

Phone: 509-769-6027

Signature: _____ Date of Request: _____
Quality Behavioral Health

APPLICANT OF INQUIRY (Name and date of birth are mandatory)

Applicant's Name: _____
Last First Middle Initial

Alias/Maiden Name(s): _____

Date of Birth: ____/____/____
Month Day Year

Signature: _____ Date: _____

By signing above you are authorizing Quality Behavioral Health to conduct a background check on you for the purpose of employment/intern/volunteer.

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OATH OF CONFIDENTIALITY

As a condition of my employment, service, consulting, auditing and/or other working relationship with

Quality Behavioral Health,

I, _____agree to the following:
(Printed Name)

I am bound by 42 Code of Federal Regulations (CFR), Part 2, federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR, Parts 160 and 164, and by Revised Code of Washington (RCW) 70.96A, Treatment of Alcoholism, Intoxication, and Drug Addiction.

I certify not to divulge to any unauthorized third party any information concerning a client, other than to another Quality Behavioral Health staff member who has a need to know, except when:

a) I have written authorized consent for the release of such information from the Client.
b) I am reporting child abuse or neglect per RCW 26.44.
c) I am reporting information concerning a crime, which is threatened to be committed either at the program, or against any person who works for the program.
d) The disclosure is a requirement of a court order, or of federal or state laws and regulations.
e) I am reporting a medical emergency that poses an immediate threat to the health of any individual and requires immediate medical attention.
f) I am ordered by a court order, which satisfies the requirements of 42 CFR, Part 2.
g) I am reporting a crime a patient has committed on the premises of/or against agency personnel.

I will consult management for direction anytime I am unclear as to the interpretation of confidentiality regulations or the legality of requests made of me for information. I agree to be bound by procedures for safeguarding client information, including:

a) All charts, notes, and other written materials will be stored in a secure room or locked up when not in use.
b) Discussions regarding clients will be held in staff offices or in other places providing assurance of privacy.
c) No privileged information will be shared with other agencies, professionals, friends, or family members without prior written authorization from the patient.
d) I will deny requests for access to patient files by anyone not employed by the agency, and refer such requests to the Executive Director.

I understand that an unauthorized disclosure of patient information or records may subject me to a civil action for damages of $1,000 or three times the amount of actual damages sustained by a willful release of confidential information under RCW 71.05.440, or state and federal criminal prosecution in accordance with 42 CFR, Part 2 and 45 CFR, Parts 160 and 164 as follows:

42 CFR, Part 2 Penalties

- Not more than $500 for the first offense and up to $5,000 for each subsequent offense.

45 CFR, Part 160 and 164 Penalties

- $100 civil fine per violation, with a maximum of $25,000 per calendar year for each standard violation. 42 USC§1320d-5(a).
- $50,000 maximum criminal fine and up to one year imprisonment if an individual knowingly makes a wrongful disclosure or wrongfully obtains protected information.

42 USC §1320 d.6.

- $1,000,000 maximum fine and 5 years imprisonment if offense is committed under false pretenses.
- $250,000 maximum fine and 10 years imprisonment if offense is committed with intent to sell, transfer, or use the protected information for commercial advantage, personal gain or malicious harm.

Additionally, I realize I am not to share information with others inside or outside of the organization, unless required by law or on a business need to know basis regarding agency business, **including financial and personnel matters.**

I understand my **Oath of Confidentiality** and these requirements do not cease at the time I terminate my relationship with the agency. I agree to be permanently bound by this oath and by the regulations of confidentiality henceforth.

Signature: _____Date: _____/_____/_____