

2026
Quality Behavioral Health
FREE
Summer Youth Program
Youth Leader Packet

2026-27 School Year
10th Grade and Older

June 24th-August 6th

Registration Packets Due: June 12th

Packets will be accepted throughout the summer as space allows.

Summer Program 2026

Dear Youth Leader:

Thank you for your interest to participate in the **Nineteenth Annual** Summer Youth Program sponsored by Quality Behavioral Health as a youth leader.

The program will offer both educational and recreational activities on 7 Wednesdays and the Grand Finale Night August 6th this summer. The program is FREE. All transportation, food, and program supplies will be provided.

To register as a youth leader, please complete and return the enclosed registration packet. Please note there are areas for you to sign as well as your parent or guardian if you are under the age of 18. The packet includes:

- Volunteer Application
- Registration - Medical History Form
- Parent/Guardian Consent and Hold Harmless/Participant Agreement/Photograph Release Form
- Medical Emergency – Contact Information Form
- Code of Conduct
- Transportation Authorization Form
- Schedule of Activities
- Background Check
- Oath of Confidentiality

All youth leaders must complete our orientation class the afternoon of June 17th 3pm to 5pm to be able to volunteer. We realize that you may not be able to participate in every activity; however, for planning purposes we would like to have a schedule of the days you will attend. Please be on time to the event, starting at 9am. If you would like to come early to help set up for the day, that is always a huge help. We end the program at 4pm.

Registration packets are due on or before the close of business on **June 12th, 2025**. Please don't hesitate to contact us if you have any questions. You can mail or turn in your packet to one of the following locations:

Clarkston Office
Quality Behavioral Health
Attn: Heather Cochrell
900 7th Street
Clarkston, WA 99403
509-758-3341
Fax: 509-758-8009

Pomeroy Office
Quality Behavioral Health
Attn: Melody Tillinghast
856 Main Street
Pomeroy, WA 99347
509-843-3791
(Packet can be placed in drop box)

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:

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 driver's 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.

Youth Leader
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. Your 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-IDENTIFICATION

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

**QUALITY BEHAVIORAL HEALTH
SUMMER YOUTH PROGRAM
MEDICAL EMERGENCY CONTACT INFORMATION**

Participant Name – Please Print Clearly

(Last) (First) (DOB)

Medical Insurance Information – Please Print Clearly

(Insurance Company Name) (Insurance Policy Number)

List any medications currently prescribed:

List any allergies, especially to medications:

(Use reverse side if you need additional space)

AGREEMENT AND CONSENT FOR TREATMENT

I understand that program activities can be physically demanding. I affirm that my child's health is good and that they are not under a physician's care for any **undisclosed** condition that might endanger their health in this activity. I realize the inherent risk of injury or disability in outdoor activities. **The parent/guardian authorizes the program sponsors, chaperones, advisors, staff members, and/or volunteers to administer emergency medical aid to the youth.** In the event that the parent/guardian cannot be reached within an appropriate period of time, given apparent medical condition of the youth, the parent/guardian hereby authorizes the transportation of the youth by ambulance, aid car, or program vehicle, to a medical facility for evaluation and treatment. The parent/guardian further consents to medical care and treatment, including, but not limited to, surgical and other procedures, by or under the supervision of a licensed health care provider, called in or otherwise selected by a staff member of any program sponsor, advisor/chaperone, and/or volunteer and to hospital care, when such care or treatment is deemed by the licensed provider to be immediately necessary or advisable in order to safeguard the youth's health. The parent/guardian acknowledges that **it is the responsibility of every individual, including the parent/guardian, to provide adequate accident and health insurance coverage for the youth** participating in the QBH Summer Youth Program and further acknowledges that the program sponsors, partners, and funding sources do not provide insurance coverage for participants.

(Parent/Guardian Signature) (Relationship to Child) (Date)

(Home Phone) (Work Phone) (Alternative
Emergency Contact #)

**QUALITY BEHAVIORAL HEALTH
SUMMER YOUTH PROGRAM**

Parent/Guardian Consent and Hold Harmless/Participant Agreement Form

The undersigned parent/guardian gives consent for _____, a minor youth, to attend and/or participate in Summer Youth Program. Said parent/guardian acknowledges that no benefits are derived by the program sponsors, by reason of the youth's participation in the program, and the parent/guardian or youth, or to the person or property of the third parties stemming from or in any way related to the youth's participation in the activity. The undersigned parent/guardian agrees to hold harmless and to indemnify and defend, the conference sponsors: Quality Behavioral Health & Garfield County Human Services, dba Quality Behavioral Health, including Board of Directors and Trustees; Garfield County Health Department; Pomeroy School District; and any community partner agency providing services through the Summer Youth Program, their directors, officers, employees, agents, volunteers, contractors, facilitators, and assigns, from and against all claims, demands, and costs, including, but not limited to attorney's fees and other defense costs, and losses of any nature whatsoever, by any person, for injury to the person or property of the parent/guardian or youth, arising out of, or in any way related to the youth's participation in the activity.

I have read and understand this Consent and Hold Harmless Form and accept its terms and conditions of the youth's participation in the Summer Youth Program and warrant that I have the authority to sign as a parent or legal guardian of the youth named above.

Name of Parent/Guardian (Please Print)

Name of Youth Participant (Please Print)

Signature of Parent/Guardian

Date

Release of Information and/or Photograph Release

Throughout the summer, SYP staff will take photos of participants during the educational and recreational activities. These photographs may be used when speaking to grant funders about our program, to be put on social media to promote the program, advertising materials during fundraisers as well as at the finale to show families about the summer's activities. I authorize (QBH) to use the name and likeness of the youth in publications relating to QBH's Summer Youth Program to include, without limitation, print, web-based publications, and social media. By initialing below, I agree: That QBH may copy, edit, enhance, crop or otherwise alter any photo, video or other media containing likeness of my child without seeking my approval. That photos, video and other media taken by QBH are the property of QBH and will not be released to me. That I am not entitled to compensation or royalties for QBH's use of my child's name and likeness.

QBH will not use your child's name and likeness in a manner that confirms their participation, if any, in direct services at Quality Behavioral Health other than Summer Youth Program.

Circle one and initial: Yes No

(Parent/Guardian Signature)

(Youth Leader Signature)

**QUALITY BEHAVIORAL HEALTH
SUMMER YOUTH PROGRAM**

Code of Conduct

1. I agree to listen to and follow instructions of all adults, guest speakers and youth leaders.
2. I agree to participate in activities and if I choose not to participate, I will sit respectfully and will not distract other participants.
3. I agree to keep all electronics, including my cell phone in my pocket or bag while presenters and SYP staff/volunteers are talking.
4. I agree to be respectful with my body and personal boundaries, for example: no hitting, kicking, pushing, kissing or any other inappropriate PDA type behaviors.
5. I agree not to use disrespectful or inappropriate language.
6. I agree to talk to a staff or volunteer if I have a problem or feel uncomfortable.

By signing this, I understand if I am to break any of the above the rules or display other inappropriate behavior I may be asked to leave the program for the duration of that day or the duration of the entire program. This will be left up to the discretion of QBH administration.

Youth Leader Name (Please Print Clearly)

Youth Leader's Signature

Date



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TRANSPORTATION AND EMERGENCY INFORMATION

By signing this document, I authorize Quality Behavioral Health staff to transport me to and from all activities associated with the Summer Youth Program and/or return me to the address or addresses listed below.

I understand that I may be transported to different locations within the following counties: Nez Perce, Latah, Whitman, Asotin & Garfield to participate in program activities. Further, I understand that some program activities may occur outside of the state of Washington and this authorization extends to all locations in which supervised program activities occur.

Youth Leader Signature

Date

SUMMER YOUTH PROGRAM

Please check the events that you believe the youth will be able to attend. We will email or call each week on Tuesday to verify attendance for the Wednesday event and to plan for food and staffing needs.

***All events are subject to change if unforeseeable change needs to be made.

_____	June 24	Anti-Bullying Presentation and Activity/Game Stations
_____	July 1	Spalding Museum and Nature Walk
_____	July 8	Suicide Prevention and Scavenger Hunt
_____	July 15	Budgeting and Terrariums
_____	July 22	Substance Use Prevention and Art Activity (Pomeroy)
_____	July 29	Internet Safety/Sexting and Bowling/Mini-Golf
_____	Aug 5	Healthy Relationships and Swimming
_____	August 6th	Grand Finale/Family Night at Beachview Park 5-7pm

Weekly Reminders

On the Tuesday before the day's events we will contact each participant and provide a pick-up time and location as well as reminders regarding what to bring for that week's activities. Please mark below your preferred form of contact. This e-mail address will ONLY be used for Summer Youth Program reminders; please do not use it for last minute notifications or to cancel or confirm other QBH appointments.

_____ Please CALL me for reminders

_____ Please E-MAIL Reminders
Preferred E-mail: _____

**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/Garfield County Human Services
900 7th Street
Clarkston, WA 99403
Attn: Trish Epling
Title: HR. Manager
Phone: 509-758-3341

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

Staff collecting form: _____

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.c

I certify not to divulge to any unauthorized third party any personally identifying information or any other 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 abuse or neglect of a vulnerable adult per RCW 74.34.
- d) 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.
- e) The disclosure is a requirement of a court order, or of federal or state laws and regulations.
- f) I am reporting a medical emergency that poses an immediate threat to the health of any individual and requires immediate medical attention.
- g) I am ordered by a court order, which satisfies the requirements of 42 CFR, Part 2.
- h) I am reporting a crime 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 Chief Compliance Officer.
- e) Communication that includes PHI is allowed by speaking face to face, phone, QBH internal email or QBH secure Zoom. PHI may not be emailed outside the agency unless QBH secure mail is used according to policy E-03 or the Electronic Communications Form is filled out and valid.

I understand that an unauthorized disclosure of patient information or records may subject me to penalties and/or a civil action in accordance with state and federal confidentiality laws.

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: _____

Vendor/Purpose of Visit: _____