CENTER FOR FAMILY SERVICES

Vision, Hope and Strength for a Better Life

CFS VOLUNTEER CONTIGENCY STATEMENT

I, _____, agree and understand that any
(Print Applicant/Volunteer Full Name)

continuation in volunteer work with Center For Family Services, Inc. is contingent upon the positive or acceptable results of some or all of the following screenings: criminal record checks, motor vehicle record check, drug screening by urine sample, physical, PPD, MMR, previous employment and personal reference, education, and licensure reference checks.

I exempt Center For Family Services, Inc. from any liability or damages, and any misrepresentation. I am aware that a negative result on any of the above named checks may have a bearing on my volunteer work, and if found may be grounds for immediate termination or eliminate me from being considered for certain volunteer opportunities.

_____	_____
Signature	**Date**
_____	_____
Position Applied For/Current Position	**Program Name**
_____	_____
Witness Full Printed Name	**Witness Position Title**
_____	_____
Witness Signature	**Date**

Volunteer Supervisor: _____ Date Submitted To HR: _____

CFS CRIMINAL RECORD REPORT DISCLOSURE AND RELEASE FOR MENTORS, VOLUNTEERS AND INTERNS

In connection with your application for mentoring, volunteering or internship an investigative consumer report and consumer reports, which may contain public information, may be requested from HireRight. Such reports may contain public record information.

You have the right to receive, upon your written request within a reasonable period of time, (not to exceed 30 days) a complete and accurate disclosure of the nature and scope of the investigation requested. You have the right to make a request to HireRight, upon proper identification, to request the nature and substance of all information in its files on you at the time of your request, including the sources of information, and the recipients of any reports on you that USIS has previously furnished within the two-year period preceding your request. HireRight may be contacted by mail at P.O. Box 33181, Tulsa, OK 74153, or by phone at 1-800-381-0645.

Attached to this disclosure is a written summary of your rights under the Fair Credit Reporting Act (FCRA) as prepared by the Federal Trade Commission.

I AUTHORIZE, WITHOUT RESERVATION, HIRERIGHT TO FURNISH A CONSUMER OR INVESTIGATIVE CONSUMER REPORT ABOUT ME TO CENTER FOR FAMILY SERVICES, INC FOR EMPLOYMENT RELATED PURPOSES.

HireRight is authorized to disclose all information obtained to CENTER FOR FAMILY SERVICES, INC. for the purpose of making a determination as to my eligibility for mentoring, volunteering or internship or any other lawful purpose. If brought on as a mentor, this authorization shall remain on file and shall serve as ongoing authorization for the procurement of investigative consumer reports and consumer reports at any time during my mentoring, volunteering or internship or contract period.

By signing below, I certify that I have read and understand this release and that I executed this release voluntarily and with the knowledge that the information being released could affect my being a mentor, volunteer or intern. This release is valid for all federal, state, county and local agencies, authorities, and governments.

_____ _____

Signature **Date**

Please Print Clearly

_____ _____

Position **Program**

_____ _____

Social Security Number **Date of Birth**

_____ _____ _____

Last Name **First Name** **Middle Name**

_____

Street Address

_____ _____ _____ _____

City **State** **Zip** **County**

I acknowledge that the above information is current and correct.

_____ _____

Signature **Date**

Supervisor: _____ Date Submitted to HR: _____

Center for Family Services STEP Program

The Center for Family Services STEP Program is a job readiness, supportive internship program for youth ages 16-19. Our mission is to help youth gain and maintain full time employment by giving them the connections and skills required in today's job market. Youth work at their sites for 4-8 hours a week, learning job skills and gaining a professional network. The sites benefit from the youth's labor and are expected to train youth and help them in their job searches.

STEP Participants receive a $100 bi-weekly stipend for their work. In order to receive this stipend, youth fill out the attached timesheet with the hours they attended their internship and the activities they participated in. Once the youth's check is ready, the STEP program will coordinate directly with the STEP youth to give them their check. Aside from signing the timesheet, STEP Sites are in no way involved with STEP Stipend distribution. All question regarding stipends should be directed to the Program Coordinator or Program Assistant.

STEP youth are responsible for:

- Attending their internship for between four and eight hours a week.
- Attending job readiness events at the Center for Family Services.
- Transportation to and from their internship site.
- Completing all tasks assigned by the mentor / site supervisor.
- Correctly completing and turning in the STEP Stipend Request Log on the 2nd and 4th Friday of every month.
- Dressing and behaving appropriately for work at the site, which includes refraining from profanity and the use of controlled substances, as well as abiding by all rules set by the site.
- Staying in touch with the STEP Program Coordinator and informing the STEP Program Coordinator of any concerns, changes in address, phone number, or status.

Mentors and their Sites are responsible for:

- Providing a safe, age appropriate site for youth.
- Providing at least four hours, and up to eight hours, of supervised work for a STEP youth.
- Helping STEP youth to build their work skills through supervised work and personal instruction.
- Verifying the accuracy of STEP Stipend Logs and, when appropriate, helping the youth to submit them.
- Staying in touch with the STEP Program Coordinator and informing the STEP Program Coordinator of any concerns, changes in address, phone number, or status.
- Refraining from profanity and the use of any controlled substances while in the presence of their mentors.

Application to be a STEP Worksite

NAME: _____ Date: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Email address: _____

Home Phone: _____ Work phone: _____ Cell Phone: _____

Date of Birth: _____ Gender: __ Male __Female

Ethnicity: Caucasian: ____ Hispanic/Latino: ____ African American: ____ Asian: ____ Other: _____

Internship Site Name: _____ Job Title: _____

Length of Employment: _____ Supervisor's Name: _____

Internship Site Address: _____

PROFESSIONAL INFORMATION:

Why would you like to work with a youth?

_____

_____

Can you commit to meet with your assigned youth, on site for at least four hours per week? _____

What would the ideal internship schedule be for a youth at your site? _____

_____

What possible duties would be offered to your assigned youth? _____

_____

Do you speak any language other than English? _____

REFERENCES:

Please list the names, addresses and phone numbers of two people for character references. List only people you have known you for at least one year.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone(s): _____ Relationship: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone(s): _____ Relationship: _____

Please read this carefully before signing:

STEP Mentoring Program appreciates your interest in becoming a workplace mentor.

Please initial each of the following:

___ I agree to follow all mentoring program guidelines and understand that any violation will result in suspension and/or termination of the mentoring relationship.

___ I understand I must return all of the following completed items along with this application and that any incomplete information will result in the delay of my application being processed

1. Criminal Record Screening Release forms, including Child Abuse and Sexual Offender Screening

By signing below, I attest to the truthfulness of all information listed on this application and agree to the above terms and conditions.

_____ _____

Signature Date

The Center for Family Services, Inc.

Client Rights & Responsibilities

Client Rights & Responsibilities were established with the expectation that observance of these rights will contribute to more effective client care and greater satisfaction for the client, family, clinician and agency. Clients shall have the following rights without regard to age, race, color, sexual orientation, national origin, religion, culture, physical handicap, personal values or belief systems.

The Client Has The Right To:

~Receive the professional care needed to regain or maintain his or her maximum potential.
~Expect clinical staff who provide service to be friendly, considerate, respectful and qualified through education and experience and perform the services for which they are responsible with the highest quality.
~Expect full recognition of individuality, including privacy in treatment and care, with confidentiality kept in regards to all communications and records.
~Complete information, to extent known, regarding diagnosis and treatment.
~Be fully informed of the scope of services available at the agency, emergency resources, and related fees for services rendered.
~Be a participant in decisions regarding the intensity and scope of treatment. If the patient is a minor, or unable to participate in those decisions, the patient's rights shall be exercised by the patient's legal guardian.
~Refuse treatment to the extent permitted by law and be informed of the consequences of such a refusal. The client accepts responsibility for his or her actions should he or she refuse treatment or not follow the treatment plan agreed on.
~Approve or refuse the release of records to any individual outside the agency, except as required by law or third-party payment contract.
~Be informed of research/educational projects affecting his or her care or treatment, and can refuse participation in such research without compromise to usual care.
~Express and / or file grievances/complaints and suggestions at any time, without interference or retaliation.
~Change primary clinician if other qualified clinicians are available.
~Be fully informed and involved before any transfer to any other service provider or organization.
~Express those spiritual beliefs and cultural practices that do not harm others or interfere with agency

State and Local Concern/Support Resources
~ Camden County Division of Mental Health
(856)374-6895
~ Gloucester County Mental Health Administrator
(856)384-6877
~ Mental Health Advocate of the Prosecutor's Office
Camden Co. (856)225-8400
Gloucester Co. (856)384-5500
~ Mental Health Association of SW New Jersey
(856)966-6767
~ NJ Dept of Consumer Affairs (201)504-6200
~ NJ Dept of Mental Health (609)567-7352

The Client Is Responsible For:

~Reporting whether he or she clearly understands the treatment plan and what is expected of him or her.
~Keeping appointments and, when unable to do so for any reason, notifying the facility 24 hours in advance.
~Recognizing that the given appointment time is dedicated to the client, and arriving on time for that appointment.
~Providing the clinician with the most accurate and complete information regarding present concerns, past history, hospitalizations, medications, changes, or any other client health or circumstance matters.
~Observing the rules of the agency during his or her treatment and, if instructions or agreed plan is not followed, forfeits the right to care at the agency is responsible for the outcome.
~Promptly fulfilling his or her financial obligations to the agency.
~Reporting any change in insurance, financial ability, and status.

Grievance Procedure:

If a client feels he/she has a grievance, attempts should be made to resolve the concern with the counselor. If this does not resolve the issue, the client may ask to see the Program Director. In consultation with the VP, the Program Director will respond to the complaint within ten days. The decision is made in writing with copies going to the client.

If there is still no resolution, the client may appeal directly to the Vice President and/or CEO/President of the Agency, who is responsible to address the complaint within fifteen working days. If the decision does not meet the needs of the client, the client may then request in writing a conference with the Executive Committee of the Board, who will arrange a conference within fifteen working days. While these hearings are informal, the client may bring a person of their choice with them to assist in presenting the concern. At a grievance conference, the client, witnesses & staff shall have equal opportunity to:

*Present and establish relevant facts
*Discuss, question or refute material
*Examine relevant records available

The Executive Committee's decision is made in writing, and copies go to the client, CEO, and on file with the Committee. The Agency will maintain confidentiality in all client grievance procedures and information.

At any point, the client may contact an outside agency to respond to concerns or provide praise for services. A list of resources is listed in the box to the right.

NOTICE OF PRIVACY PRACTICES

This notice describes how healthcare and service information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

This notice is provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996.

Center For Family Service is committed to protecting your personal information. We create a record of the treatment and services you receive at the Center. We need this record to ensure the quality, continuity and effectiveness of your care. In keeping with our caring culture, the Center strives to maintain a balance between protecting your privacy, providing quality treatment and ensuring your health and safety. This notice describe how we may use and disclose your protected health information to carry out treatment, payment, healthcare operations, ensure your health and safety, and for other purposed that are permitted or required by law.

This notice also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information such as gender, ethnicity, date of birth, diagnosis and telephone number that may identify you and that relates to your past, present or future physical or mental health, condition and related healthcare services.

The Center is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. A new notice will be effective for all protected healthcare or service information that we maintain at that time.

A copy of the Notice of Privacy Practices will be given to you at the time you first enroll for services at the Center (for enrollments on or after Aprill4, 2003). Upon request, we will provide you with any revised Notice of Privacy Practices. A copy of our Notice of Privacy Practices is available on our website www.centerffs.org. Copies are also available from your program or the Agency's Privacy Officer:

Sue Bergmann, Vice President of Administration
Center For Family Services
584 Benson Street
Camden, NJ 08103856-964-1990

CENTER FOR FAMILY SERVICES
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

CENTER FOR FAMILY SERVICES HAS A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION.
All employees, volunteers, staff, doctors, health professional and other personnel are legally required to and must abide by the policies set forth in this notice, and to protect the privacy of your health information.

This "protected health information" includes information that can be used to identify you. We collect or receive this information about your past, present or future health condition to provide health care to you, or to receive payment for this health care. We must provide you with this notice about our privacy practices that explain how, when and why we use and disclose (release) you Protected Health Information. With some exceptions, we may not use or release any more of your Protected Health Information than is necessary to accomplish the need for the information. We must abide by the terms of this notice of privacy practices currently in effect.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the Protected Health Information already in existence. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby. You can also request a copy from the contact person listed at the end of this notice at anytime and can view a copy of the notice on our Website: www. centerffs.org

WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION for many different reasons. Below we describe the different categories of when we use and release your Protected Health Information **without your consent.**

A. WE MAY USE, OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

1. For Treatment. We may share your Protected Health Information among physicians, nurses, psychologists, social workers, interns, and other health care personnel who are directly involved in your health care at this agency. **For example:** your primary therapist and your medication provider will share your protected health information to provide the best care for you. For external disclosures we will always ask for your authorization before we disclose your health information, except in emergencies to other mental health agencies or units.

2. **To obtain payment for treatment.** We may use and release your Protected Health Information in order to bill and collect payment **from you** for services provided to you. It is important that you provide us with correct and up-to-date information. **For example:** we may release portions of your Protected Health Information to our billing department to get paid for the health care services we provided to you. We may also release your Protected Health Information to our business associates, such as billing companies.

3. **To run our health care business.** We may use your Protected Health Information internally, in order to operate our facility in compliance with healthcare regulations. **For example:** we may use your Protected Health Information to review the quality of our services and to evaluate the performance of our staff in caring for you.

B. WE DO NOT REQUIRE YOUR CONSENT TO USE OR RELEASE YOUR PROTECTED HEALTH INFORMATION:

1. When federal, state, or local law; judicial or administrative proceedings; or law enforcement agencies request your Protected Health Information. We release your Protected Health Information only when a law required that we report information to government agencies or law enforcement personnel. Specifically we would notify the NJ Division of Youth and Family Services about victims or child abuse, or neglect. We would also notify Law Enforcement officials about the following: for notification and identification purposes when a crime has occurred, in missing person cases; or when ordered in a judicial or administrative proceeding, or in accordance with 42 CFR Part II.

2. About Decedents. We provide medical examiners at their request, necessary information relating to an individual's death, or in accordance with 42 CFR Part II.

3. To avoid harm. In order to avoid a serious threat to your safety or the safety of another individual, we may provide your Protected Health Information to law enforcement personnel, or to the endangered person, or to other people able to prevent or lessen such harm.

4. **For appointment reminders and health-related benefits and services.** We may use your demographic Protected Health Information to contact you as a reminders that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

5. For health oversight activities. We report information about serious incidents, including deaths, to the NJ Department of Human Services, and Department of Health and Senior Services. We may use and disclose your Protected Health Information. We may use and disclose your Protected Health Information to a health oversight agency, including NJ Department of Health and Senior Services, Medicaid, Medicare, or your Health Insurance Plan, for oversight activities authorized by law, including audits, licensure, or other activities necessary for oversight of the health care system or disciplinary actions against our workforce.

C. YOUR PRIOR WRITTEN AUTHORIZATION IS REQUIRED FOR ANY USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION NOT INCLUDED ABOVE.

1. To obtain payment form your health care plan for treatment. Pending your signed Consent for Release of information and Payment for Medical Benefits Form, we may use and release your Protected Health Information to your health plan in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-to-date information.

2. Information shared with family, friends, and others. We will only release your Protected health Information to a family member, friend, or other person that you indicate is involved in your care if you agree to the disclosure by completing and signing an Authorization Form.

We will ask for your written authorization before using or releasing any of your Protected Health Information. If you choose to sign an authorization to release your Protected Health Information, you may later cancel that authorization in writing. This will stop any further release of your Protected Health Information for the purposes you previously authorized.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

A. You Have the Right to Request Limits on How We Use and Release Your Protected Health Information. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit Protected Health Information that we are legally required or allowed to release.

B. You Have the Right to Choose How We Communicate Protected Health Information to You. All of our communications to you are considered confidential. You have the right to ask that we send information to you to an alternative address (for example, sending information to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. Any additional expenses will be passed on to you for payment.

C. You Have the Right to Request to See and Get Copies of Your Protected Health Information. You must make the request in writing. We will respond to you within 10 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, why we denied your request. You may have the right to have the denial reviewed by a committee. You can request a summary or a copy of your Protected Health Information as long as you agree to the cost in advance. If your request to see your Health Information is approved, we will arrange this in accordance with established policy. Please submit all requests for this information to the Director of the Program in which you are receiving services, or the Vice President of Administration.

D. You Have the Right to Get a List of Instances of When and to Whom We Have Disclosed Your Protected Health Information. This list **will not** include uses you have already authorized, or those for treatment, payment or operations. This list will not include disclosures made before April 14, 2003. We will respond within 60 days of receiving your request. The list will include dates when your Protected health Information was release and the purpose, with whom your Protected Health Information was released (including their address if known), and a description of the information released. The first list you request within a 12-month period will be free. You will be charged a reasonable fee for additional lists within that time frame. Please submit all requests for this information to the Director of the Program in which you are receiving services, or the Vice President of Administration.

E. You have the Right to Correct or Update Your Protected Health Information. If you believe that there is a mistake in your Protected Health Information or that a piece of important information is missing, you have the right to request that we correct the existing or add the missing information. We can do this for as long as the information is retained by our facility. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. If we deny your request, our written denial will state our reasons and explain your right to file a written statement of disagreement. If you do not file a written statement of disagreement, you have the right to request that your request and our denial be attached to all future uses or release of your Protected Health Information. If we approve your request, we will make the change to your Protected Health Information, tell you that we have done it, and tell others that need to know about the change or amendment to your Protected Health Information. Please submit all requests for this information to the Director of the Program in which you are receiving services, or the Vice President of Administration.

F. You have the Right to Receive This Privacy Notice. You have the right to request another paper copy of this notice at any time.

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your Protected Health Information, you may file a complaint with our Privacy Official listed below. You also may send a written complaint to the Secretary of the Department of Human Services.

You will not be penalized for filing a complaint.

PERSON TO CONTACT FOR INFORMATIN ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES: Our Privacy Official: Vice President of Administration 856-964-1990

Effective date of this Law: April 14, 2003

Vision, Hope and Strength for a Better Life

REFERENCE AUTHORIZATION FORM

I, _____, authorize Center for Family Services,
(Print Full Name)

Inc. to obtain employment references and/or personal references for employment or volunteer work from the organizations and/or persons that I have listed and/or given on my resume, volunteer application, and/or as references during the application and interviewing process. I understand that the results may have a bearing on my volunteering with Center for Family Services, Inc.

_____ _____
Signature **Date**

_____ _____
Position Applied For/Current Position **Program Name**

Volunteer Supervisor: _____ Date Submitted To HR: _____