

- | | | |
|---|---|--|
| <p>5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client?
If Yes, explain, including when and where it happened.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>6. Has any government or regulatory agency (other than the police) ever found that you abused an elderly person?
If Yes, explain, including when and where it happened.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?
If Yes, explain, including credential name, limitations or restrictions, and time period.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |

SECTION B – OTHER REQUIRED INFORMATION

- | | | |
|---|---|--|
| <p>1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services?
If Yes, explain, including when and where it happened.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility?
If Yes, explain, including when and where it happened and the reason.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>3. Have you been discharged from a branch of the US Armed Forces, including any reserve component?
If Yes, indicate the year of discharge:
Attach a copy of your DD214, if you were discharged within the last three (3) years.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>4. Have you resided outside of Wisconsin in the last three (3) years?
If Yes, list each state and the dates you resided there.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years?
If Yes, list each state and the dates you resided there.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>6. Have you had a caregiver background check done within the last four (4) years?
If Yes, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |
| <p>7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe?
If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.</p> | <p>Yes
<input type="checkbox"/></p> | <p>No
<input type="checkbox"/></p> |

Read and initial the following statement.

I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

<p>NAME – Person Completing This Form</p>	<p>Date Submitted</p>
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HIPAA Form 03 — Acknowledgment of Receipt by Persons Served of Notice of Privacy Practices

Form for Policy 120:3 A, Policies for Protection of the Privacy of Protected Health Information. **Section V.C.**

St. Coletta of Wisconsin, Jefferson, WI 53549

Page 1 of 1

Name of individual: _____ ID Number: _____

This is to acknowledge my receipt of St. Coletta's *Notice of Privacy Practices* pertaining to persons served.

Please note: Each individual served by St. Coletta of Wisconsin will receive this form to sign even if he/she has a Guardian/Personal Representative in order to assure that all individuals receive the *Notice of Privacy Practices* and are aware of their rights under HIPAA.

Signatures:

1. Individual

Printed name: _____

Signature: _____ Date signed: _____

2. Guardian/Personal Representative (if applicable)

Printed name: _____

Relationship to individual (mother, father, brother, sister, friend, etc.): _____

Address: Street: _____

City, State, Zip: _____ Telephone: _____

Description of representative's authority to act for the individual, if applicable: _____

Signature: _____ Date signed: _____

Notice of Privacy Practices

St. Coletta of Wisconsin, Jefferson, WI 53549

Effective January 1, 2018 — Page 1 of 4

This notice explains how your personal medical information may be used and disclosed and how you can have access to this information. Please review it carefully.

This notice is to tell you how we may use and disclose protected health information. Protected Health Information includes any health information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In the header above, that information is referred to as “medical information”. In this notice, we simply call all such Protected Health Information, “health information”.

This notice also tells you about your legal rights and our duties with respect to your health information. In addition, it tells you how to file a complaint if you believe your privacy rights have been violated.

How We May Use and Disclose Health Information About You

We may use and disclose your health information for a number of different purposes as described below:

For Treatment. We may use your health information to provide, coordinate, or manage the services, supports, and health care you receive from us and other providers. We may disclose your health information to doctors, nurses, Case Coordinators/Qualified Intellectual Disabilities Professionals (QIDPs), psychologists, social workers, direct support staff and other agency staff, volunteers, and other persons who are involved in supporting you or providing care. We may consult with other health care providers concerning you, and as part of the consultation, share your health information with them. For example, our employees may discuss your information to develop and carry out your Individual Service Plan. They may share information to coordinate needed services, such as medical tests, transportation to a doctor’s visit, physical therapy, etc. They may also need to disclose health information to entities outside of our organization (for example, another provider or a state/local agency) to obtain new services for you.

For Payment. We may use and disclose your health information so we can be paid for the services we provide to you. This may include billing a third party payer, such as Medicaid or other state agency (for example, the state’s Office of Intellectual Disabilities), or your insurance company. For example, we may need to provide Medicaid program information about the 18 services we provide to you to the state in order to be reimbursed for those services. We also may need to provide the state Medicaid office information to ensure you are eligible for the Medical Assistance program.

For Health Care Operations. We may use and disclose health information about you for our own operations. These are necessary for us to operate St. Coletta of Wisconsin and to maintain quality services for the people we serve. For example, we may use health information about you to review the services we provide and the performance of our employees supporting you. We may disclose health information about you to train our staff and volunteers. We also may use the information to study ways to more efficiently manage our organization, for accreditation or licensing activities, or for our compliance program.

How We Will Contact You. Unless you tell us otherwise in writing, we may contact you by telephone /cellphone or by mail or by email at either your home or your workplace. At either location, we may leave messages for you on an answering machine or voice mail. If you want to request that we communicate to you in a certain way or at a certain location, see “Right to Receive Confidential Communications” in this Notice.

Appointment Reminders. We may use and disclose your health information when we contact you to remind you of an appointment for treatment or services.

Treatment and Service Alternatives. We may use and disclose your health information when we contact you about treatment and service alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose your health information when we contact you about health-related benefits and services that may be of interest to you.

Marketing Communications. We may use and disclose your health information when we communicate with you about a product or service to encourage you to purchase the product or service. This may be:

- ▶ To describe a health-related product or service that is provided by us
- ▶ For your treatment
- ▶ For case management or care coordination for you
- ▶ To direct or recommend alternative treatments, therapies, health care providers, or settings of care

Fund Raising. St. Coletta will only release general group demographic information that cannot be individually identified when fund raising.

St. Coletta of Wisconsin Directory. We may include your name, your location in our facility, your condition described in general terms, and your religious affiliation in our directory while you receive services. This information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, such as a minister, priest, or rabbi. If you do not want to be included in our facility directory, or if you want to restrict the information we include in the directory, you must notify the Director of Case Management Services, St. Coletta of Wisconsin, N4637 County Road Y, Jefferson, WI 53549, of your objection.

Disclosures to Family and Others. We may disclose your health information to your parent/guardian, personal representative, family member, other relative, a close personal friend, or any other person identified by you. We will only disclose information that is directly relevant to that person's involvement with the services and supports you receive or payment for those services and supports. We may also use or disclose health information about you to notify, or assist in notifying, those persons of your location, general condition, or death. If you want to disallow someone you have identified, please notify the Director of Case Management Services, St. Coletta of Wisconsin, N4637 County Road Y, Jefferson, WI 53549, or tell the person who is providing care to you.

Required by Law or Disaster Relief. We may use or disclose your health information when we are required to do so by law. We may also use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. This will be to coordinate with those entities in notifying a parent/guardian, personal representative, family member, other relative, close personal friend, or other person identified by you of your location, general condition, or death.

Judicial and Administrative Proceedings. We may disclose your health information when required by a judicial or administrative proceeding in response to an order of the court or administrative tribunal, or in response to a subpoena, discovery request, or other legal process.

Public Health Activities. We may disclose your health information for legally required public health activities and purposes. This could be for purposes of preventing or controlling disease, or about child abuse and neglect or for purposes related to the quality, safety, or effectiveness of a United States Food and Drug Administration-regulated product or activity.

Victims of Abuse, Neglect, or Domestic Violence. We may disclose your health information to a government authority legally authorized to receive reports of abuse, neglect, or domestic violence, if we believe you are a victim of abuse, neglect, or domestic violence.

Health Oversight Activities. We may disclose your health information to a health oversight agency if legally required for audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are required for appropriate oversight of the health care system, government benefit programs, and entities subject to various government regulations.

Coroners, Medical Examiners, and Funeral Directors. We may disclose your health information to a coroner or medical examiner or Funeral Director as necessary for them to carry out their duties.

Organ, Eye, or Tissue Donation. If you or your legal representative have authorized such a donation, we may disclose your health information to facilitate organ, eye, or tissue donation and transplantation to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue.

To Avert Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

Your Rights With Respect to Your Health Information

You have the following rights with respect to your health information that we maintain:

Right to Receive Confidential Communications. You or your legal representative have the right to request your health information and that it is sent to you in a certain way or at a certain location. For example, you can ask that we only contact you by email or by US postal mail. You are not required to tell us why you are asking for the confidential communication.

Please send your request, which must be in writing, to the Director of Case Management Services, St. Coletta of Wisconsin, N4637 County Road Y, Jefferson, WI 53549.

Right to Request Restrictions. You or your legal representative have the right to request that we restrict the uses or disclosures of health information about you to carry out treatment, payment, or health care operations unless it is required by law. For example, you could ask that we not disclose health information about you to your brother or sister. You or your legal representative may request or withdraw a restriction at any time. It must be a written request to the Director of Case Management Services, St. Coletta of Wisconsin, N4637 County Road Y, Jefferson, WI 53549, telephone 920/674-8334,

Right to Amend. You have the right to ask us to amend your health information which St. Coletta has documented. We will review your request and if it is approved, we will revise your health information. If it isn't approved, you will be notified of the reason(s). You also have the right to add a statement to your health information for as long as the health information is maintained by us.

Your request must be in writing and sent to the Director of Case Management Services, St. Coletta of Wisconsin, N4637 County Road Y, Jefferson, WI 53549.

Right to an Accounting of Disclosures. You have the right to receive information about any disclosures of your health information to other entities during the prior six (6) years except those required for legal or healthcare oversight agency purposes. The accounting may be for up to six (6) years prior to the date on which you request the accounting but not before April 14, 2003.

Please submit your request in writing to the Director of Case Management Services, St. Coletta of Wisconsin, N4637 County Road Y, WI 53549.

Right to Copy of this Notice. You may request a copy of our *Notice of Privacy Practices* at any time as follows:

Over the Internet at our web site, www.stcolettawi.org.

From our Director of Case Management Services, St. Coletta of Wisconsin, N4637 County Road Y, Jefferson, WI 53549, telephone 920/674-8334.

Our Duties

Generally. We are required by law to maintain the privacy of your health information and to provide you and other individuals with notice of our legal duties and privacy practices with respect to health information. We are required to abide by the terms of our *Notice of Privacy Practices* in effect at the time, and its effective date will be specified.

Our Right to Change *Notice of Privacy Practices*. We reserve the right to change this *Notice of Privacy Practices* at any time and for any reason

Availability of *Notice of Privacy Practices*. A copy of our current *Notice of Privacy Practices* will be posted on our web site, www.stcolettawi.org. A copy may also be obtained by writing to our Director of Case Management Services, St. Coletta of Wisconsin, N4637 County Road Y, Jefferson, WI 53549, telephone 920/674-8334.

Complaints. You may complain to us and/or to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You will not be retaliated against for filing a complaint.

To file a complaint with us, please write our Director of Human Resources, St. Coletta of Wisconsin, N4637 County Road Y, Jefferson, WI 53549. To file a complaint with the United States Secretary of Health and Human Services, send your complaint to him/her in care of: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201.

Questions and Information. If you have any questions or want more information about our *Notice of Privacy Practices*, please contact the Director of Case Management Services, St. Coletta of Wisconsin, N4637 County Road Y, Jefferson, WI 53549, telephone 920/674-8334

Office Use Only

Type of Volunteer:

Assignment Interests:

Date Started:

Form for Policies 510,
Volunteers, and 514,
Internships

Volunteer/Unpaid Intern Application

St. Coletta of Wisconsin, Jefferson, WI 53549

Mission Statement of St. Coletta of Wisconsin

Inspired by the Franciscan Values of compassion, dignity, and respect, we support people with developmental and other challenges in achieving their highest quality of life, personal growth, and spiritual awareness.

June 12, 2003

Please Note: This form is used in the matching process, so please be as thorough and honest as possible. This form has three pages—please answer all information. If information is not applicable, please indicate by writing "NA". Please print or write clearly.

General Information

First Name: _____ Middle: _____ Last: _____

Gender: Male Female

Preferred Name (nickname): _____ Date of Birth (month, day, year): _____

Address: _____
Street City State Zip

Telephone Number: _____ E-mail: _____

School/Agency through which you are volunteering: _____

In case of emergency, please notify:

Name: _____ Telephone Number: _____

Address: _____
Street City State Zip

Relationship to you: Mother Father Legal Guardian
 Other (please explain): _____

Previous Experience

Have you ever worked or volunteered at St. Coletta? ___ Yes ___ No If yes, when and in what capacity?

List any previous volunteer experience: _____

Previous employment applicable to working as a volunteer/intern: _____

Previous experiences with people with cognitive disabilities: _____

Are there any other experiences, skills, or qualifications that will be of benefit in a volunteer/intern experience?

For Volunteers only:

Volunteer Preferences: Please check those activities that you can coach, direct, participate in comfortably, assist in, or enjoy.

- | | | | |
|--|-------------------------------------|---|---|
| <input type="checkbox"/> Clerical | <input type="checkbox"/> Scouts | <input type="checkbox"/> Aerobics | <input type="checkbox"/> Concerts |
| <input type="checkbox"/> Chaperone | <input type="checkbox"/> Tour Guide | <input type="checkbox"/> Baseball | <input type="checkbox"/> Plays |
| <input type="checkbox"/> Crafts | <input type="checkbox"/> Tutoring | <input type="checkbox"/> Basketball | <input type="checkbox"/> Art |
| <input type="checkbox"/> Driver | <input type="checkbox"/> Walks | <input type="checkbox"/> Bowling | <input type="checkbox"/> Special Olympics |
| <input type="checkbox"/> Fishing | <input type="checkbox"/> Shopping | <input type="checkbox"/> Computer Games | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Music | <input type="checkbox"/> Greenhouse | <input type="checkbox"/> Ice/Roller Skate | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Religious Ed. | <input type="checkbox"/> Sports | <input type="checkbox"/> Play cards | |

Other (please list): _____

What are the reasons you want to volunteer/intern at St. Coletta and what are you hoping to gain? _____

Availability

Please shade in the times in the table below that you are *available* to volunteer:

	9:00 a.m.	10:00 a.m.	11:00 a.m.	12:00 p.m.	1:00 p.m.	2:00 p.m.	3:00 p.m.	4:00 p.m.	5:00 p.m.	Evening
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Personal References (do not include relatives)

Full Name	Address (Number and Street, City, State, Zip Code)	Telephone Number (include Area Code)

Additional Information

Have you ever been convicted of a criminal offense? ___Yes ___ No If yes, please explain: _____



Volunteer

Participation Agreement

Name of Person Requesting Participation: _____

Contact Information: Phone #: _____ Email: _____

Address: _____

Emergency Contact (Name and Phone #): _____

Your Organization If Applicable: _____

Activity or Event: _____

Dates of Activity or Event: _____

Previous Experience/Training with DD Population: _____

This agreement covers volunteer participation in any St. Coletta of Wisconsin activities or events by individuals who are not directly employed or receiving services from St. Coletta.

Individuals over age 18 may sign on their own behalf. Individuals under age 18 must have a parents' or guardian's permission and agreement to be on St. Coletta's premises and to participate in the approved activity or event. The following Terms and Conditions must be complied with at all times and are hereby understood and agreed to without exception:

TERMS AND CONDITIONS

- Smoking.** St. Coletta of Wisconsin is a non-smoking, tobacco-free organization and does not allow any smoking or use of tobacco on the property including inside or outside any buildings.
- Participation in Activity or Event.** Individual shall only participate in the activity or event that is hereby approved. He or she shall not participate in any other activity or event without similar written permission from St. Coletta of WI Inc. St. Coletta reserves the right to revoke any participation approval at any time and for any reason.
- Indemnity.** It is agreed that St. Coletta of Wisconsin, Inc. shall not be liable for any injury or damage to the individual, other persons who may accompany the individual, or any of his or her possessions. Upon signing this agreement, the individual, or guardian, hereby agrees to indemnify and hold St. Coletta of Wisconsin, Inc., its Directors, Officers, Agents and Employees harmless from any and all claims for injuries or damages of any kind.
- Laws, Ordinances and Statutes.** The Individual shall comply with all applicable local, state, and federal laws, ordinances and statutes related to the activity or event. This agreement shall be solely governed, construed and interpreted under the laws of the State of Wisconsin.
- Change.** Any change or approval of any kind on the part of St. Coletta of Wisconsin, Inc. must be specific and in writing or it shall have no effect.
- Background Check.** Individual hereby consents to St. Coletta Conducting a Background Check at any time.

St. Coletta of Wisconsin, Inc. Signature

Date

Individual's Signature

Date

Parent or Guardian's Signature
