

**Capper Foundation
Youth Volunteer Application**

Last Name First Name Middle Name (Nickname)

Street address City/State Zip Code

Home Phone Cell phone e-mail address Birth Date

Mother's Name Home address & phone (if different) Business Phone

Father's Name Home address & phone (if different) Business Phone

School attending & Grade _____

Organizations that you belong to: _____

Volunteer Experiences: _____

Describe any valid certificates which you possess: _____

Issued by: _____ Date issued: _____

Do you have a valid Kansas Driver's License? Yes / No

The organization may conduct a personal reference / background investigation regarding employment, education, or criminal background verifications. By signing this application, you authorize the organization to make these investigations, and you indicate your awareness that false statements or failure to disclose information may be sufficient to disqualify you from volunteering.

Signature of Volunteer _____ Date _____

Volunteer Name _____

PERSONAL REFERENCES: (Will be contacted)

Name	Address	Phone	Relationship
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Name	Address	Phone	Relationship
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Name	Address	Phone	Relationship
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EMERGENCY CONTACT:

Name	Relationship	Phone	E-Mail
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Name	Relationship	Phone	E-Mail
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Please check all areas of interest to you:

- | | | |
|---------------------------------------|----------------------------------|-----------------------------------------|
| <u>Recreation</u> | <u>Sports</u> | <u>Other</u> |
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Boccia | <input type="checkbox"/> Special Events |
| <input type="checkbox"/> Track | <input type="checkbox"/> Soccer | <input type="checkbox"/> Computer |
| <input type="checkbox"/> Music | <input type="checkbox"/> Bowling | <input type="checkbox"/> Paperwork |
| <input type="checkbox"/> Yoga | <input type="checkbox"/> Tennis | <input type="checkbox"/> Mailings |
| <input type="checkbox"/> Martial Arts | | <input type="checkbox"/> Data Entry |

Days Available

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Hours Available

Additional comments: _____

<u>Office use only</u>	<u>Policy Overview</u>	<u>Recognition / Awards</u>
Application date: _____	Volunteer _____	_____
Interview date: _____	Safety _____	_____
Reference date: _____	Accident _____	_____
Orientation date: _____	Emergency _____	_____
Beginning date: _____	Information _____	_____

I, _____, give permission for the release of information concerning
(PRINT Full Name)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* _____ **Phone** _____

Agency name _____

Agency mailing address _____

Email address: Will return via Encrypted email unless marked otherwise _____

Maiden Name and/or Other Names Known By: _____

(PRINT ONLY)

Address: _____

Street _____ **City** _____ **State** _____ **Zip Code** _____

DOB: _____ **SS#:** _____ Male Female
(mm/dd/yyyy) **(mark one)**

I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse, Neglect, Exploitation Central Registry each year while I am employed or associated with the above agency. Yes No

Signature: _____ **Date:** _____
(An Ink Signature or a Verified E-Signature is Required for Processing) **(mm/dd/yyyy)**

RETURN TO:

Email: DCF.APSRegistry@ks.gov

Mail: Office of Background Investigations

Adult Abuse Registry

P.O. Box 751043

Topeka, Kansas 66675

(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

For Official Use Only: Mark in this area if PROHIBITED

For Official Use Only: Mark in this area if CLEARED



KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
Child Abuse and Neglect Central Registry
P.O. Box 2637 • Topeka, KS 66601 • DCF.CentralRegistry@ks.gov
Release of Information

Complete form by printing legibly in ink. Fee of \$10.00 per Release of Information form may be required prior to processing.
All releases and fees are to be sent to the address or email listed above (see below for specifics)
CONFIDENTIALITY: *Kansas Department for Children and Family records are confidential. No individual, association, partnership, corporation, or other entity shall willfully or knowingly disclose, permit, or encourage disclosure of the contents of records or reports in violation of the confidentiality requirements of K.S.A. 38-2209. Violation of this statute is a class A nonperson misdemeanor and the court may impose a civil penalty of up to \$1,000.*

Contact Person: Kristin Fischer Agency/Org.: Capper Foundation
 Phone #: 785-246-6587 Address: 3500 SW 10th Ave
 Email: kfischer@capper.org City/State/Zip: Topeka, KS 66604

Return Results by: Encrypted email (list if different than above): _____ Postal Mail

Payment/Account Information (check box which applies)

<input type="checkbox"/> <i>Fee included</i>	\$10 per request. Check, Money Order (payable to DCF) or cash. Postal mail only.	
<input type="checkbox"/> <i>Online Payment*</i>	www.dcf.ks.gov – ‘Online DCF Payments’ bottom of page. Payment Portal. Submit receipt with ROI form(s).	
<input checked="" type="checkbox"/> <i>Pre-Pay Account*</i>	Agency/Org. has Pre-Pay Account.	FEIN: 48-0543745
<input type="checkbox"/> <i>Mentoring Account*</i>	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/Find-a-Program	
<input type="checkbox"/> <i>Exempt*</i>	No fee for State government agencies (Sub-contracting agencies not included).	

*Release of Information forms may be submitted via email to DCF.CentralRegistry@ks.gov

APPLICANT: *Instructions: PRINT CLEARLY. All requested information is required for processing. Incomplete or illegible information will result in processing delays for the Release of Information. Use 'N/A' rather than leaving a space blank.*

FIRST, MIDDLE, LAST NAME: _____

I give permission for the release of any of my information in the Child Abuse/Neglect Central Registry to the contact listed above. I understand the information released is for their exclusive and confidential use: Yes No
This organization/person/agency may check my information each year I am employed or associated with them: Yes No

OTHER NAMES USED: (Any/all aliases, married, maiden, nicknames, etc. 'N/A' if none used.): _____

DATE OF BIRTH: _____ **RACE:** _____

SOCIAL SECURITY #: _____ **GENDER:** Male Female

CURRENT ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ **EMAIL:** _____

SIGNATURE: _____ **DATE:** _____

DCF ONLY:

MATCH		CLEARED
<i>This applicant is listed in the Child Abuse/Neglect Central Registry.</i> <i>Per KSA 65-504 and 65-516 this person prohibited from working, residing, or volunteering in a licensed child care home or facility.</i> (see attached document for more info.)		



AUTHORIZATION FOR PHOTO RELEASE

____ I give permission for myself and/or _____
to have my/her/his picture, words, or voice used for marketing materials promoting Capper Foundation.
I understand that this can include, but not limited to; photography, video use, social media, websites,
training activities, brochures, banners or published articles with the following conditions:

- ____ I prefer to remain anonymous (no name used).
- ____ I prefer the use of first name(s) be used (no last name).
- ____ I prefer ONLY for internal use in Capper Foundation.

-OR-

____ I DO NOT give permission for any use listed above

Signature (individual/parent/guardian name)

Date

Relationship

The signature above indicates my authority to sign on behalf of this child. This release will remain in effect for those images indefinitely, unless otherwise revoked by a parent, guardian, or child after turning 18 years of age.



Capper Foundation
3500 SW 10th Avenue
Topeka, KS 66604
785-272-4060 FAX 785-272-7912
www.capper.org

Capper Foundation
Confidentiality and Security Agreement

The Health Insurance Portability and Accountability Act (HIPAA) applies to all volunteers/students and others who represent Capper while providing care and services to our patients (including outpatients and recreation participants). HIPAA regulations assure a patients' right to privacy and to control their health information. As an observer or volunteer/student at Capper Foundation you may see or hear confidential/protected health information about children and adults receiving services. You may also be exposed to proprietary and confidential management, financial and human resources information.

I understand that:

- 1. All patient information is confidential.
2. Any breach of confidentiality has the potential to cause great emotional stress to the patient and could result in a law suit against me and/or Capper.
3. Any information I may learn concerning a patient should be considered highly confidential and should not be repeated to anyone - not my spouse, best friend - anyone. This is not only a policy of Capper Foundation but also a Federal law.

I agree that:

- 1. I will only access information I need to do my volunteer work.
2. I will not show, tell, copy, give, sell, review, change or trash any confidential patient information.
3. I will protect the privacy of Capper consumers/patients.
4. I will not share proprietary and confidential information even if I am no longer a Capper volunteer/student.
5. I will not discuss confidential information in places at Capper where I may be overheard, i.e. elevators, break room, hallway.

Failure to comply with this agreement may result in the termination of my volunteer/student work at Capper Foundation and/or civil or criminal legal penalties. By signing this, I agree that I have read, understand and will comply with this agreement.

Printed name _____ Date _____

Signature _____

If volunteer is under age 18:

Signature of Parent or Guardian _____ Date _____