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 my 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 _____

Rev 10/2013

Volunteer Name _____

PERSONAL REFERENCES: (Will be contacted)

Name	Address	Phone	Relationship
Name	Address	Phone	Relationship
Name	Address	Phone	Relationship

EMERGENCY CONTACT:

Name	Relationship	Phone	E-Mail
Name	Relationship	Phone	E-Mail

Please check all areas of interest to you:

- ☐ Swimming
- ☐ Track
- ☐ Music
- ☐ Yoga
- ☐ Martial Arts
- ☐ Boccia
- ☐ Soccer
- ☐ Bowling
- ☐ Tennis
- ☐ Special Events
- ☐ Computer
- ☐ Paperwork
- ☐ Mailings
- ☐ Data Entry

	Hours Available
Monday	_____
Tuesday	_____
Wednesday	_____
Thursday	_____
Friday	_____
Saturday	_____

Additional comments:_____
_____
_____

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

STATE OF KANSAS
Department for Children & Families
Office of Background Investigations

ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

OBI 10400
REV 4/22

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)* Kristin Fischer **Phone** _____

Agency name Capper Foundation

Agency mailing address _____

Email address: Will return via Encrypted email unless marked otherwise kfischer@capper.org

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
Strong Families Make a Strong Kansas

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)

☐ *Fee included*	$10 per request. Check, Money Order (payable to DCF) or cash. ***Postal mail only.***	
☐ *Online Payment**	www.dcf.ks.gov – 'Online DCF Payments' bottom of page. Payment Portal. Submit receipt with ROI form(s).	
X *Pre-Pay Account**	Agency/Org. has Pre-Pay Account.	FEIN: 48-0543745
☐ *Mentoring Account**	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/Find-a-Program	
☐ *Exempt**	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
This applicant is listed in the Child Abuse/Neglect Central Registry. *Per KSA 65-504 and 65-516 this person prohibited from working, residing, or volunteering in a licensed child care home or facility.* (see attached document for more info.)		

Capper FOUNDATION

AUTHORIZATION FOR PHOTO RELEASE

____ I give permission for myself/my child _____
first and last name
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 (post sharing by third parties including individuals and/or businesses is possible), 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 (volunteer or parent/guardian name) Date

_____
Relationship

The signature above indicates my authority to sign on behalf of this individual. This release will remain in effect indefinitely, unless otherwise revoked by the volunteer, 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_____