Coulee Council On Addictions
Bridging the Gap Between Addiction and Recovery

Volunteer Application

INSTRUCTIONS:
This application is required to volunteer with Coulee Council on Addictions, Inc. Once you have completed the form please sign it. To complete the volunteer application process, all pages and all information in this packet needs to be filled in.

Signed volunteer applications will be accepted in-person, mail, fax, or email. Once your application has been received it will be reviewed. You will be notified of your application status as soon as possible. Thank you for your interest in Coulee Council on Addictions.

CONTACT INFORMATION		
First Name:	Last Name:	Date:
Address:		
City:	State:	Zip:
Cell Phone:	Other phone:	Email:
EMERGENCY CONTACT		
First Name:	Last Name:	Phone Number:
PERSONAL INFORMATION		
Are you volunteering to fullfill community services obligations? _____ yes _____ no		
If yes, how many hours required? _____	Probation Officer Name:	
Do you have any physical or other limitation(s)? _____ yes _____ no If yes, please explain:		
VOLUNTEER INTERESTS AND EXPERIENCES		
Volunteer Interests: Number 1-4 in order of interest. 1 being most interested and 4 being least interested.		
_____ Eduation _____ Prevention _____ Fundraising _____Recovery Center _____ No preference		
Please list any previous volunteer experience:		
Organization:		Volunteer Activity:
Why do you want to volunteer here?		

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CHARACTER AND REFERENCES		
Have you ever been convicted of a felony? _____ yes _____ no		
If yes, please explain:		
Please provide two character references (At least one non-family member):		
Full Name:		Relationship:
Phone:		Alternative Phone:
Email:		
Full Name:		Relationship:
Phone:		Alternative Phone:
Email:		

AVAILABILITY							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From							
To							
Date available to start:							

DECLERATION AND SIGNATURE

I understand that this application expresses my interest in volunteering with Coulee Council on Addictions. The information provided on this application is true and complete to the best of my knowledge. I understand if falsified information has been given on this application it will be grounds for removal of consideration or termination of my volunteering.

I agree to follow the rules, expectations and requirements of the Coulee Council and the volunteer program that I will be associated with. I understand that not following hem is grounds for dismissal. I further understand that I am responsible for any building keys given to me; that they will remain in my possession; will not be used at times other than authorized and will be returned to CCA staff or authorized volunteer upon request.

Signature:	Date:

Coulee Council on Addictions, Inc.
921 West Ave. S.
La Crosse, WI 54601
Phone: (608) 784-4177
Fax: (608) 784-6302
E-mail: cca@couleecouncil.org

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PLEDGE OF CONFIDENTIALITY

As a Coulee Council On Addictions, Inc. employee, volunteer, community services worker, or worker or volunteer under any special program in any capacity, while on or off the premises, 921 West Avenue S., whether on or off duty, I agree to the following:

I will comply with all confidentiality rules, policies, and laws regarding matters pertaining to CCA staff, clients, volunteers, workers, and drop-ins.

I understand the confidentiality rules, policies, and laws set forth by the program I am working in, Coulee Council on Addictions, Inc., and local, state and federal governments.

If I do not understand the confidentiality requirements that apply while I am involve in any way with Coulee Council, I will ask my immediate supervisor to help me understand. If I still so not understand, I will ask for explanation from the Executive Director of Coulee Council. I understand that lack of understanding does not relieve me from my responsibility to adhere to them.

I understand that by not following these rules, policies, and laws regarding confidentiality that I am putting myself at risk for dismissal as a volunteer or employee; and at risk for legal consequences.

By signing and dating this document I signify my understanding and willingness to comply with all of the above.

_____ _____

Signature Date

LIVE UNITED United Way

921 West Ave. S La Crosse, WI 54601 p 608-784-4177 f 608-784-6302 cca@couleecouncil.org

COULEE COUNCIL ON ADDICTIONS, INC.
921 West Avenue S, La Crosse, WI 54601
Phone: (608) 784-4177 Fax: (608) 784--6302

Coulee Council On Addictions

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

(PLEASE COMPLETE IN FULL)

1. Client Information

Name – Last, First, MI _____ Maiden _____

Street Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Date of Birth _____

2. Authorizes: Coulee Council on Addictions, Inc.

☐ Other (please specify):_____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

3. Disclosure of Protected Health Information to:

_____
Name (i.e. Parent/Guardian, spouse, ect.)

Street Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

I further authorize the two-way exchange of information between the above organizations for the duration of this agreement. *Please Circle* Yes No

4. Type of information to be disclosed. (Check all categories that apply. Specify dates or time periods when known.)
Information to be released may be in Written, Verbal, Voice Mail, Fax or Electronic Form INFORMATION TO BE RELEASED. Check all categories that apply.

☐ Mental Health ☐ Substance Abuse/Dependency ☐ Verbal written exchange of information

☐ Diagnostic summary ☐ Treatment Plan ☐ Progress notes ☐ Aftercare plan/Discharge summary

☐ Psychological Testing/Psychiatric Evaluation **X** Other:(specify) Emergency Contact/Attendance and Participation

5. Purpose or need for disclosure.

☐ Treatment Planning ☐ Follow-up ☐ Probation/Parole - Treatment Compliance

☐ Coordination of services ☐ Collateral For Assessment Purpose ☐ Legal

☐ Military Recruitment **X** Other: (Specify) Emergency Contact/Attendance and Participation

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I understand that my records are protected under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Client Records, 42CFR2, 45 CFR Part 164, HFS 92 and chapter 51, WI Stats., and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This authorization may be revoked in writing at any time prior to the disclosure of this information. This authorization will expire in twelve months from the date below unless you specify it. If release is for less than twelve months specify below. (See reverse side for more information). I also understand that I have a right to inspect and receive a copy of the material to be disclosed as required under ss. HFS 92.05 and 92.06. (See HFS 92.03 (3)(d) requirement.)

Records to be disclosed are between the dates of:_____ and _____

Signature of Client:_____ **Date:**_____
If signed by a person other than the Client, state relationship and authority to do so. (See reverse side for signing authority.)

Client is: ☐ Minor ☐ Incompetent ☐ Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Biological Parent of Minor
☐ Spouse of Deceased ☐ Health Care Agent
☐ Personal Representative of Deceased
☐ Other:_____

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Coulee Council on Addictions, Inc. recognizes the Client's rights to confidentiality of Client health. Therefore, you should be aware of the following guidelines when requesting medical records. The numbers listed below correspond to the numbered sections on the authorization.

4. Generally, all Clients 18 years of age and older must sign for disclosure of their own health information. Read the following to determine exceptions for Clients older or younger than 18 years for age.

a. All Clients 18 years of age and over must sign for disclosure of health information, unless the following conditions apply.
   1) The Client is incompetent.
   2) The Client is incapacitated and cannot sign the form.
   3) The Client is deceased.

b. HIV Test Results.
   1) Wisconsin Law: All Clients 14 years of age or older must sign for disclosure of HIV test results. Parental consent is not sufficient. For Clients less than age 14, a parent or guardian may sign.

c. Mental Health Treatment Records:
   1) Wisconsin Law: All Clients 14 years of age or older may sign for disclosure of Client information involving treatment for mental illness or developmental disabilities. Parents generally may also consent, unless denied physical placement of the Client. When a parent consents for a Client 14 years if age or older, it is recommended that the Client sign also.

d. Alcohol & Drug Abuse Treatment Records:
   1) Wisconsin Law: Clients 12 years of age or older must sign for the disclosure of alcohol and drug abuse records unless, the treating physician determines the minor lacks capacity, because of extreme youth or mental or physical conditions, to make a rational decision whether to consent to disclosure to parents is needed, or parental consent was required for the treatment in the first place.

e. When a Client is incapacitated, a person appointed as guardian or temporary guardian may sign with proper legal paperwork. If the Client has given written authorization to another person to disclose health information the designated person can sign. Generally family members of living adult Clients do not otherwise have authority sign.

f. When the Client is deceased, the surviving spouse or personal representative, with proper legal paperwork, of the Client may sign authorizations disclosing health information. When there is no surviving spouse, immediate family may consent. For this purpose, immediate family is limited to adult children, parents, grandparents, adult brothers and adult sisters of the deceased Client and their spouses.

g. All persons signing for disclosure of health information, instead of the Client, must state their relationship to the Client and have available proof of legal authority to disclose health information. The above summary does not address all the complex exceptions that permit others to authorize disclosure.

6. Wisconsin Statues recognize the need for informed consent. The Client may request multiple disclosures of the information stated on the authorization form. However, all disclosures based on this form are limited to records dates up to and including the date of the Client's signature. A new authorization is necessary for disclosure of Client health information on care provided after the date of the Client's signature, unless:

a. You check the "additional period" box and "include future records" box, or
b. You specify a different time period in section 4.

BACKGROUND INFORMATION DISCLOSURE (BID) INSTRUCTIONS

The Background Information Disclosure form (F-82064) gathers information as required by the Wisconsin Caregiver Background Check Law to help employers and governmental regulatory agencies make employment, contract, residency, and regulatory decisions. Complete and return the entire form and attach explanations as specified by employer or governmental regulatory agency. **NOTE:** If you are an owner, operator, board member, or non-client resident of a Division of Quality Assurance (DQA) facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

CAREGIVER BACKGROUND CHECK LAW

In accordance with the provisions of Chapters 48.685 and 50.065, Wis. Stats., for persons who have been convicted of certain acts, crimes, or offenses:

1. The Department of Health Services (DHS) may not license, certify, or register the person or entity (Note: Employers and Care Providers are referred to as "entities");
2. A county agency may not certify a child care or license a foster or treatment foster home;
3. A child placing agency may not license a foster or treatment foster home or contract with an adoptive parent applicant for a child adoption;
4. A school board may not contract with a licensed child care provider; and
5. An entity may not employ, contract with or, permit persons to reside at the entity.

The list of offenses affecting caregiver eligibility that require rehabilitation review is available from the regulatory agencies or through the Internet at https://www.dhs.wisconsin.gov/caregiver/statutes.htm.

THE CAREGIVER LAW COVERS THE FOLLOWING EMPLOYERS / CARE PROVIDERS (Referred to as "Entities"):

Programs Regulated under Chapter 48, Wis. Stats.	Treatment Foster Care, Family Child Care Centers, Group Child Care Centers, Residential Care Centers for Children and Youth, Child Placing Agencies, Day Camps for Children, Family Foster Homes for Children, Group Homes for Children, Shelter Care Facilities for Children, and Certified Family Child Care.
Programs Regulated under Chapters 50, 51, and 146, Wis. Stats.	Emergency Mental Health Service Programs, Mental Health Day Treatment Services for Children, Community Mental Health, Developmental Disabilities, AODA Services, Community Support Programs, Community Based Residential Facilities, 3-4 Bed Adult Family Homes, Residential Care Apartment Complexes, Ambulance Service Providers, Hospitals, Rural Medical Centers, Hospices, Nursing Homes, Facilities for the Developmentally Disabled, and Home Health Agencies – including those that provide personal care services.
Others	Child Care Providers contracted through Local School Boards

THE CAREGIVER LAW COVERS THE FOLLOWING PERSONS:

- Anyone employed by or contracting with a covered entity who has access to the clients served, except if the access is infrequent or sporadic and service is not directly related to care of the client. Exception: Emergency medical technicians and first responders are not covered under the Caregiver Law.
- Anyone who is a Child Care Provider who contracts with a School Board under Wisconsin Statute 120.13 (14).
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client ("non-client resident").
- Anyone who is licensed by DHS.
- Anyone who has a foster home licensed by DHS.
- Anyone certified by DHS.
- Anyone who is a Child Care Provider certified by a county department.
- Anyone registered by DHS.
- Anyone who is a board member or corporate officer who has access to the clients served.

FAIR EMPLOYMENT ACT

Wisconsin's Fair Employment Law, Chapters 111.31 – 111.395, Wis. Stats., prohibits discrimination because of a criminal record or pending charge; however, it is not discrimination to decline to hire or license a person based on the person's arrest or conviction record if the arrest or conviction is substantially related to the circumstances of the particular job or licensed activity.

PERSONALLY IDENTIFIABLE INFORMATION

This information is used to obtain relevant data as required by the provisions set forth by the Wisconsin Caregiver Background Check Law. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches. For example, the Department of Justice uses social security numbers, names, gender, race, and date of birth to prevent incorrect matches of persons with criminal convictions. The Department of Health Services' Caregiver Misconduct Registry uses social security numbers as one identifier to prevent incorrect matches of persons with findings of abuse or neglect of a client or misappropriation of a client's property.

DEPARTMENT OF HEALTH SERVICES
Division of Enterprise Services
F-82064 (02/2014)

STATE OF WISCONSIN
Chapters 48.685 and 50.065, Wis. Stats.
DHS 12.05(4), Wis. Admin. Code

BACKGROUND INFORMATION DISCLOSURE (BID)

For Instructions, see F-82064A.
Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. Failure to comply may result in a denial or revocation of your license, certification, or registration; or denial or termination of your employment or contract. Refer to the instructions (F-82064A) on page 1 for additional information. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.

PLEASE PRINT OR TYPE YOUR ANSWERS.

Check the box that applies to you.

☐ Employee / Contractor (including new applicant)
☐ Applicant for a license or certification or registration (including continuation or renewal)
☐ Household member / lives on premises – but not a client
☐ Other – Specify:

NOTE: If you are an owner, operator, board member, or non-client resident of a Division of Quality Assurance (DQA) facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Name – (First and Middle)	Name – (Last)	Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)	

Any Other Names By Which You Have Been Known (Including Maiden Name)	Birth Date	Gender (M / F)

Race
☐ American Indian or Alaskan Native ☐ Black ☐ Unknown
☐ Asian or Pacific Islander ☐ White

Social Security Number(s)

Home Address	City	State	Zip Code

Business Name and Address – Employer or Care Provider (Entity)

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
1. Do you have any criminal charges pending against you or were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts? ➢ If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.	☐	☐
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.) ➢ If **Yes,** list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.	☐	☐
3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked: ❑ (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.) ➢ If **Yes**, explain, including when and where it happened.	☐	☐
4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? ➢ If **Yes,** explain, including when and where it happened.	☐	☐
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.	☐	☐

Last Name –

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
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.	☐	☐
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.	☐	☐

SECTION B – OTHER REQUIRED INFORMATION	YES	NO
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.	☐	☐
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.	☐	☐
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 3 years.	☐	☐
4. Have you resided outside of Wisconsin in the last 3 years? ➢ If **Yes**, list each state and the dates you lived there.	☐	☐
5. Have you had a caregiver background check done within the last 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.	☐	☐
6. 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.	☐	☐

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to $1,000.00 and other sanctions as provided in DHS 12.05 (4), Wis. Adm. Code.

SIGNATURE	Date Signed