LAKEVIEW VOLUNTEER APPLICATION

Name ______________________________________
Last First Full Middle

Home Address ______________________________ Telephone ______________

cell ______________ E-mail address ______________________

Birth date ______________________

In Case of Emergency ______________________ Telephone Home ______________
Name/ relationship

Work ______________

Cell ______________

______________________ Telephone Home ______________
Name/ relationship

Work ______________

Cell ______________

Any Health Limitations /allergies ______________________________

Previous Work Experiences ______________________________

Previous/Present Volunteer Jobs ______________________________

Length of Commitment ______________ (i.e.: 3 mo. 6 mo. 1 yr.)

Circle all that apply: weekly, 2 times per month, 1 time per month

Hobbies, Interest, Special Skills

____

____

Do You Have Transportation Available? ______________

X SIGNATURE: ______________________________ ______________
Name Date

VOLUNTEER OPPORTUNITIES

____Arts & Crafts
____Baking
____Bingo (music/regular)
____Church Escort
____Elevator Escort
____Entertainment
____Game Night Aide
____Gardening/water plants

____ Group Activity Aide
____Mailings

____Mealtime Assistance
____One to One Visiting
____Piano/ music/sing
____Seasonal Decorator
____Saturday Activity Aide
___ Share-a-pet

___ Water Pitchers
___ Write Letters

LAKEVIEW METHODIST HEALTH CARE CENTER

610 Summit Drive
Fairmont, MN 56031
Phone (507) 235-6606 Fax (507) 235-3995

APPLICANT & EMPLOYEE SCREENING FORM

Applicant name:______________________________ Date:________________

This form is to be used by owners to screen applicants and employees who have the means, within the scope of their duties, to enter tenants' dwelling units (apartments, rooms, homes, etc.).

HAVE YOU BEEN CONVICTED OF ONE OF THE FOLLOWING CRIMES OR AN ATTEMPT TO COMMIT ONE OF THE FOLLOWING CRIMES? PLEASE CHECK APPROPRIATE BOX:

	YES	NO
First degree murder (MN Stat 609.185)	☐	☐
Second degree murder (MN Stat 609.19)	☐	☐
First degree manslaughter (MN Stat 609.20)	☐	☐
First degree assault (MN Stat 609.221)	☐	☐
Second degree assault (MN Stat 609.222)	☐	☐
Third degree assault (MN Stat 609.223)	☐	☐
Kidnapping (MN Stat 609.25)	☐	☐
First degree criminal sexual conduct (MN Stat 609.342)	☐	☐
Second degree criminal sexual conduct (MN Stat 609.343)	☐	☐
Third degree criminal sexual conduct (MN Stat 609.344)	☐	☐
Fourth degree criminal sexual conduct (MN Stat 609.345)	☐	☐
First degree arson (MN Stat 609.561)	☐	☐
Felony harassment & stalking (MN Stat 609.749)	☐	☐

HAVE YOU BEEN CONVICTED OF ONE OF THESE CRIMES, OR AN ATTEMPT TO COMMIT ONE OF THESE CRIMES, IN ANOTHER STATE? ☐ Yes ☐ No

If you answered yes to the last question, list the state, crime and year of conviction:

State__________ Crime ______________________ Year Convicted ____________

State__________ Crime ______________________ Year Convicted ____________

I HEREBY CERTIFY THAT MY ANSWERS TO THESE QUESTIONS ARE TRUE, COMPLETE AND ACCURATE. I UNDERSTAND THAT IF I KNOWINGLY GIVE FALSE INFORMATION, OR WITHHOLD INFORMATION, IN ANSWERING THESE QUESTIONS, I MAY BE SUBJECT TO DENIAL OF EMPLOYMENT OR IMMEDIATE TERMINATION OF MY EMPLOYMENT.

______________________________ ______________________
SIGNATURE OF APPLICANT OR EMPLOYEE DATE

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CRIMINAL BACKGROUND CHECKS – NOTICE OF RIGHTS

MINNESOTA LAW NOW REQUIRES OWNERS TO CONDUCT A CRIMINAL BACKGROUND CHECK OF ALL APPLICANTS AND EMPLOYEES WHO HAVE THE MEANS, WITHIN THE SCOPE OF THEIR DUTIES, TO ENTER TENANTS' UNITS. THE LAW REFERS TO THESE INDIVIDUALS AS "MANAGERS".

AS A "MANAGER" YOU HAVE THE RIGHT:

TO KNOW THAT WE WILL ASK YOU TO COMPLETE A FORM THAT WE WILL SUBMIT TO ONE OR MORE CRIMINAL BACKGROUND CHECKERS. THE CRIMINAL BACKGROUND CHECKER(S) MAY BE THE MINNESOTA BUREAU OF CRIMINAL APPREHENSION, A LOCAL LAW ENFORCEMENT AGENCY AND/OR PRIVATE SCREENING AGENCY. THE CRIMINAL BACKGROUND CHECKER WE WILL USE TO CHECK YOU BACKGROUND IS: <u>DEPARTMENT OF HUMAN SERVICES, BACKGROUND STUDY UNIT 444 LAFAYETTE ROAD ST PAUL, MN 55155.</u>

WE WILL USE YOUR SIGNED FORM AND THIS SIGNED NOTICE, TO REQUEST THE CRIMINAL BACKGROUD CHECKER(S) TO CONDUCT A CRIMINAL BACKGROUND CHECK ON YOU. THE INFORMATION YOU PROVIDE ON THAT FORM WILL BE USED BY THE CRIMINAL BACKGROUND CHECKER(S) TO REVIEW YOUR CRIMINAL BACKGROUND HISTORY. THE CRIMINAL BACKGROUND CHECKER(S) WILL DETERMINE IF YOU HAVE BEEN CINVICTED OF ONE OF THE CRIMES LISTED ON THE ATTACHED EMPLOYEE SCREENING FORM. EACH CRIMINAL BACKGROUND CHECKER WILL SEND US A REPORT CONTAINING THIS INFORMATION.

TO BE INFORMED BY LAKEVIEW METHODIST OF THE REPORT(S) WE RECEIVE FROM THE CRIMINAL BACKGROUND CHECKER(S) TO OUR REQUEST FOR A CRIMINAL BACKGROUND CHECK.

TO OBTAIN FROM US A COPY OF THE REPORT(S) WE RECEIVE FROM THE CRIMINAL BACKGROUND CHECKER(S).

TO OBTAIN FROM THE CRIMINAL BACKGROUND CHECKER(S) COPIES OF THE RECORDS THAT FORM THE BASIS FOR THEIR RESPONSE OR REPORT.

TO CHALLENGE THE ACCURACY AND COMPLETENESS OF THE INFORMATION CONTAINED IN THE REPORT(S), AS ALLOWED BY MINNESOTA'S GOVERNMENT DATA PRACTICES ACT, MINNESOTA STATUES SECTION 13.04, SUBDIVISION 4.

TO BE INFORMED BY LAKEVIEW METHODIST IF YOUR APPLICATION TO BE A "MANAGER" HAS BEEN REJECTED BASED ON THE RESULT OF THE CRIMINAL BACKGROUND CHECK.

TO BE INFORMED BY LAKEVIEW METHODIST IF WE TERMINATE YOUR EMPLOYMENT BASED ON THE RESULTS OF THE CRIMINAL BACKGROUND CHECK.

I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THIS NOTICE OF MY RIGHTS AS A "MANAGER" APPLICANT OR EMPLOYEE.

______________________________ ______________________________
SIGNATURE OF APPLICANT OR EMPLOYEE DATE

MN Department of Human Services
Licensing Division
Background Check Division
444 Lafayette Road North
St. Paul, MN 55155-3842
651-296-3971 / 651-282-6832 (TTY)

OPTIONAL: Items marked with an asterisk (*) are optional. All other information is required.

PLEASE PRINT

NAME
First: _______________ **Middle** (*):_____________**Last**: _________________

Date of Birth: ___________________ (mm/dd/yyyy) **Age**:_______

Gender: _____Male ____Female

Minnesota DL # or State ID (*) : _______________________________

Race (*): ________________________ Asian, Pac. Islander, African American, Native American, Caucasian, Unknown/Other

Social Security Number (*): ___________________

Phone (*): ________________________

Address:____

City: _________________ **State**:_______________ **Zip**: ______________

Other First names you have used: ________________________________

Other Last names you have used: ________________________________

Signature: ____

LAKEVIEW HEALTH SERVICES

610 Summit Drive
Fairmont, MN 56031
Phone (507)235-6606 Fax (507)235-3995

Privacy Notice:

MINNESOTA DEPARTMENT OF HEALTH LICENSED FACILITIES SUPPLEMENTAL NURSING SERVICES AGENCIES, EDUCATIONAL PROGRAMS, TEMPORARY EMPLOYMENT AGENCIES, PROFESSIONAL SERVICES AGENCIES

BACKGROUND STUDY PRIVACY NOTICE

Because the Minnesota Department of Human Services is requesting that you provide private information about yourself, the Minnesota Government Data Practices Act requires that you be informed of the following:

1. Purpose and intended use of the information: Minnesota Statutes, section 144.057, requires the Minnesota Department of Human Services (DHS) to conduct background studies on individuals who have direct contact with patients and residents in hospitals, boarding care homes, outpatient surgical centers, nursing homes, home care agencies, residential care homes, board and lodging establishments registered to provide supportive or health supervision services, individuals employed by supplemental nursing services agencies, and controlling persons of a supplemental nursing services agency; and all other employees in nursing homes. The background studies are to be completed according to the requirements in Minnesota Statutes, chapter 245C. The information requested will be used to perform a background study of you that will include at least a review of criminal conviction records held by the Minnesota Bureau of Criminal Apprehension and records of substantiated maltreatment of vulnerable adults and children. DHS may also later require you to submit additional information and/or your fingerprints if necessary to complete your background study. For all individuals who are subject to background studies by DHS, the corrections system will report new criminal convictions for disqualifying crimes to DHS. County agencies and the Minnesota Department of Health report substantiated findings of maltreatment of minors and vulnerable adults to DHS.

2. Whether you may refuse or are legally required to provide the information: Minnesota Statutes, chapter 245C, states that the individual who is the subject of a study must provide sufficient information to ensure an accurate background study.

3. Known consequences that may arise from supplying the information: Individuals who have histories with the characteristics identified in Minnesota Statutes, chapter 245C, will be disqualified from positions allowing direct contact with (and, where applicable, access to) persons receiving services. Health-related licensing boards will make a determination whether to impose disciplinary or corrective action on individuals regulated by health-related licensing boards who have been determined to be responsible for substantiated maltreatment. Individuals who do not have disqualifying characteristics will not be disqualified.

4. Known consequences that will arise from refusing to supply the requested information: Only items identified as "optional" may be left blank. Refusal to provide the information necessary to ensure an accurate and complete background study will result in your disqualification and an order to the agency or facility to remove you from any position allowing direct contact with (and, where applicable, access to) persons receiving services.

5. Identification of other agencies or entities authorized to receive this information: The information you provide will be shared with the Minnesota Bureau of Criminal Apprehension. If DHS has reasonable cause to believe that other agencies may have information pertinent to a disqualification, the information may also be shared with county attorneys, county sheriffs, courts, county agencies, local police, the Federal Bureau of Investigation, the Office of the Attorney General, agencies with criminal record information systems in other states, and juvenile courts. Background study results may be shared with the Minnesota Department of Health, the Minnesota Department of Corrections, the Office of the Attorney General, non-licensed personal care provider organizations, and health-related licensing boards. If you have a disqualifying characteristic, the facility will be told only that you are disqualified and will not be told what caused your disqualification, unless you were disqualified for refusing to cooperate with the background study or for serious and/or recurring maltreatment of a minor or vulnerable adult. The information about you received as part of a background study is classified as private data and, except for the agencies noted, cannot be shared without your consent.

Signature:____ Date:____________

PRIVACY OF HEALTH INFORMATION AGREEMENT

I have been trained and understand my responsibility to protect residents' privacy and to maintain confidentiality.

I take seriously my responsibility to protect resident information.

I understand that failure to comply with the applicable Privacy requirements will result in disciplinary action up to, and including, termination.

In addition, I understand that criminal penalties may be applied to a person who violates the H.I.P.A.A. (Health Insurance Portability and Accountability Act of 1996) statute.

____________________________ ____/____/____

Employee / Volunteer Signature — Date Signed

____________________________ ____/____/____

Employee/Volunteer Name- Printed

Media Release Form

I grant permission for my picture/name to be used for public relations in regards to the Lakeview Campus.

Yes ____ No____

Name ______________________________
(please print)

Signature:_________________________(parents must sign if minor)

CONFIDENTIALITY AGREEMENT

As a volunteer at Lakeview, I realize that I will have access to confidential information, and I understand the importance of maintaining this confidentiality. Therefore, I agree not to divulge to unauthorized persons any information regarding Lakeview Campus Residents. Unauthorized person's inlcude: family members, the media, other agencies, staff or volunteers. I understand that inappropriate use of confidential material is sufficient grounds for dismissal from Lakeview and the possibility of criminal or civil charges being brought against me.

________________________________ ________________
Volunteer Date

________________________________ ________________
Staff Representative Date