

# How to complete the Volunteer Application:

Please read this carefully and follow all instructions:

Vista Maria is a childcare institution licensed by the State of Michigan. Vista Maria is required to ensure that all persons having contact and ongoing duties shall be of good moral character, emotionally stable and of sufficient health, ability, experience and meet required qualifications to perform in a specific role or to perform assigned duties.

Volunteers are required to successfully complete all requirements to ensure compliance with COA, regulatory agencies, government regulations and Vista Maria policies which include: TB test; Michigan, Department of Human Services clearance; and any other background checks as required.

1. The Volunteer Application is made up of several parts. Please be sure to answer all components of the application. These include:
  - **Personal Information** – Vista Maria shares none of your personal information with outside sources. Files are kept within the Volunteer Department.
  - **Emergency Contact Information**– For purposes of contacting the individual you identify in case of an emergency.
  - **Employment Contact Information** – For purposes of contacting you in the event of an activity/appointment/group cancellation.
  - **Education Information** – For student interns and workshop groups
  - **Volunteer Availability**
  - **Program of Interest** – To determine which volunteer activities you are interested in pursuing
  - **Criminal History Record Check Consent and Sex Offender Registry** – Please include **both** your driver’s license number and social security number. These items are needed to run your criminal history record check. These items are not shared with sources outside of Vista Maria; all files are kept within the Volunteer Department.
  - **References** – Please supply the agency with three completed reference forms from *PROFESSIONAL* references only. No family members please.
  - **Conflict of Interest & Discipline Policy Acknowledgement** – Please read & sign
  - **Confidentiality and Policy Acknowledgement** – Please read & sign
2. **Tuberculosis Test Procedures:** All VM Volunteers are required to obtain a current TB test. If you have had a negative TB reading in the past year, please return a copy of the negative screen to the Volunteer Program. Should a test be needed, the volunteer is responsible for obtaining a negative TB test.
3. **Department of Human Services Clearance:** As of April 2003, all staff & volunteers are required by law to receive a DHS Central Registry Clearance, which can be obtained by filling out the attached form, and dropping it off at your local DHS office. Upon completion, please return to volunteer services. A list of offices can be found attached to this document. Please be sure to take your social security card and driver’s license along. This form is to ensure there are no pending or substantiated child abuse charges against you, which will in turn, ensure the safety of our girls.
4. **HIPPA Acknowledgement:** Please read this document carefully.

# Vista Maria Volunteer Application

*Applicants are considered for Volunteer positions without regard to race, color, religion, gender, national origin, age, marital or veteran status, sexual orientation or the presence of a handicap or medical condition not related to their ability to perform necessary volunteer duties. Selection of volunteers to fill positions at Vista Maria or community based programs is based on skills, program requirements, and the ability of volunteers to work within the parameters of the Good Shepherd Philosophy.*

## **Personal Information**

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Date of Application: \_\_\_\_\_ Applicant Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Sex:  Male  Female

Applicant Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

License Plate #: \_\_\_\_\_ Car Model: \_\_\_\_\_

Color: \_\_\_\_\_ Year: \_\_\_\_\_

Have you applied to work or volunteer at Vista Maria in the past?  Yes  No

If yes, was your application accepted?  Yes  No

If yes, please list dates and capacity of your involvement:

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How did you hear about Vista Maria's Volunteer Program?

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Describe your interest in being a volunteer for Vista Maria or Community Based Programs:

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Describe any volunteer work you have done in the past:

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What are your motivations to become a volunteer at Vista Maria?

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Describe any training, classes, certification, or experiences, talents, and skills that will help you in your volunteer responsibilities:

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Do you currently know any child that resides at Vista Maria?     Yes     No

If yes, please explain:

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Have you ever been *convicted* of or pled *no contest* to a felony or misdemeanor?     Yes     No

Felony Degree (if known): \_\_\_\_\_

State/County: \_\_\_\_\_ Date: \_\_\_\_\_

Sentence/Fine: \_\_\_\_\_

If yes, please explain:

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Do you have any physical, mental, medical impairment or disability that would limit your performance as a volunteer with Vista Maria?     Yes     No

If yes, please explain:

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### **Emergency Contact Information**

In the event of an emergency, please provide the name of the individual we can contact:

Name of Emergency Contact: \_\_\_\_\_ Relationship to Emergency Contact: \_\_\_\_\_

Phone Number of Emergency Contact: \_\_\_\_\_

### **Employment Information**

Name of Employer: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ May we call you at work?     Yes     No

## Education Information

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School: \_\_\_\_\_ Degree/Major: \_\_\_\_\_

## Volunteer Availability

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Please indicate days and times you are available by providing an "x" in the appropriate boxes

	MON	TUE	WED	THU	FRI	SAT	SUN
8 a.m.							
9 a.m.							
10 a.m.							
11 a.m.							
12 p.m.							
1 p.m.							
2 p.m.							
3 p.m.							
4 p.m.							
5 p.m.							
6 p.m.							
7 p.m.							
8 p.m.							
9 p.m.							

## Program of Interest

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I am interested in volunteering as a

- |  |   |
|--|---|
| <input type="checkbox"/> Volunteer Mentor  | <input type="checkbox"/> Student Intern           |
| <input type="checkbox"/> Volunteer Tutor   | <input type="checkbox"/> Heartmover               |
| <input type="checkbox"/> General Volunteer | <input type="checkbox"/> Substance Abuse Recovery |
|  | <input type="checkbox"/> Community Service        |

## Criminal History Record Check Consent/Sex Offender Registry

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As a prospective employee/volunteer of Vista Maria, I understand that it is this agency's policy to secure conviction criminal history information as part of their pre-employment screening process using the information provided below.

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Race: \_\_\_\_\_ Gender: \_\_\_\_\_

Previous Names: \_\_\_\_\_ County \_\_\_\_\_

Drivers License: \_\_\_\_\_

How long have you lived in Michigan? \_\_\_\_\_ Prior? \_\_\_\_\_

I understand that the above information is required by the Central Records Division of the Michigan State Police, Lansing, Michigan. I authorize Vista Maria to utilize the above information for the sole purpose of obtaining a conviction-only criminal history file search.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Reference Information

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I understand that it is my responsibility to supply Vista Maria with three completed reference forms prior to the start of my volunteer services

### TO BE COMPLETED BY PROSPECTIVE VOLUNTEER:

Name: \_\_\_\_\_

Name of Reference: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### TO BE COMPLETED BY REFERENCE:

The above individual has applied to us for a position as a volunteer. Please provide the information requested.

In what capacity have you known this applicant? \_\_\_\_\_

How long have you known this applicant? \_\_\_\_\_

### Appraisal of Applicant:

Please rate the applicant to the best of your ability on a scale of 1-5, with one being the lowest and five being the highest.

a.	<i>Commitment and Consistency</i>	1	2	3	4	5
b.	<i>Assessment Skills</i>	1	2	3	4	5
c.	<i>Skills working with People</i>	1	2	3	4	5
d.	<i>Communication &amp; Mediation Skills</i>	1	2	3	4	5
e.	<i>Knowledge of &amp; skills to work with teen girls</i>	1	2	3	4	5
f.	<i>Acceptance of diverse cultures, religions, etc.</i>	1	2	3	4	5

Please describe the applicant in 3-5 words: \_\_\_\_\_

\_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Reference: \_\_\_\_\_ Date: \_\_\_\_\_

## **Conflict of Interest Acknowledgement**

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I hereby acknowledge that, as an employee, agent, consultant, volunteer or other person involved in the operations of Vista Maria, I am prohibited from having a direct or indirect interests in the assets, leases, business transactions and professional services beyond what the Agency is obligated to provide me the form of pay or consultant fees.

In the events that a financial transaction is pending or has taken place which will benefit me directly or indirectly, I am obligated to inform the Executive Director or Board of Directors of the conflict of interest, and to furnish proof that the benefits will not accrue to me.

I acknowledge that failure to adhere to the Conflict of Interest policy is cause of action, which may sever my relationship with Vista Maria.

## **Discipline Policy Acknowledgement**

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Discipline practices are consistent with the philosophy, mission and goals of Vista Maria and must be clearly understood by all employees of the Agency. The practices are in compliance with the Licensing Regulations of the State of Michigan.

When a child appears to be out of control, begins to act aggressively, or in a way harmful to herself, other children, and/or staff, appropriate intervention by staff is essential using the principles of NVPCI (Non-Violent Physical Crisis Intervention).

Corporal punishment in any form in never, under any circumstances to be used. All forms of physical and/or verbal abuse are prohibited, since they contribute to the degradation of the person. Withholding of meals, mail, sleeping time and family contact is prohibited. Undignified language, cursing and swearing are viewed as verbal abuse. Spanking, paddling, pinching, twisting of arms, pulling hair, etc, is also abusive.

It is expected that every Volunteer/Mentor of Vista Maria will use common sense, good judgment and a respect for the person of the child. Every Volunteer/Mentor is expected to seek out and gain experience from the Vista Maria staff, and/or the Program Manager of Volunteer Resources when assistance is needed. If there is a question, please ask.

<hr/>	
Signature	Date

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Volunteer Program Staff Signature	Date

## Confidentiality and Policy Acknowledgement

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I hereby acknowledge my recognition that all information concerning Vista Maria's clients is confidential and agree to hold such information in confidence regardless of whether this information was ascertained from written materials or pursuant to verbal discussions with clients or other Vista Maria Volunteers.

I recognize my obligations as a Vista Maria Volunteer to adhere to, the following policies, procedure or statutory provision:

1. Vista Maria's procedure for client record and client information Confidentiality Policy
2. All laws relating to the disclosure of information on serious communicable diseases, including HIV/Aids status of Agency clients or employees
3. Should information be disclosed to a volunteer regarding suicidal threat, threat to building security, planned truancy, abuse, or anything which threatens a person's safety by a resident, I must report this conversation to the supervisor before I leave that evening.
4. I am not authorized to give my home telephone number, business address or any home, business, cell phone, and/or email address to any Vista Maria resident
5. I am required to remove myself from any crisis situation and follow all directions from Vista Maria staff. I recognize that I am not to discuss details of a crisis with clients unless so directed and supervised by staff.
6. I do not have the authorization to enter resident bedrooms and bathroom areas. I do have authorization to access staff restrooms.
7. I recognize that small gifts can be presented to clients, with prior permission of the unit supervisor. Gifts should be limited to special events/holidays/birthdays
8. Letter writing between Volunteers and Clients is prohibited.
9. The unit supervisor must first screen all books, pamphlets, and videos given/provided to the girls by a volunteer.
10. I must be safety and security conscious by not bringing dangerous items like scissors or glass into the units.
11. Should a resident wish to speak to me privately; it must be done in an area easily seen by unit staff.
12. I must obtain prior approval from the assigned therapist and Program Manager of Volunteer Resources before bringing guests so that we can notify the shift supervisor.

If a violation of the Volunteer Policy occurs, every effort will be made to resolve the situation. A meeting will be held with the Volunteer, Volunteer Program Staff and any other relevant administrative staff. If the violation can be corrected, the Volunteer will be welcome to return to their position in the agency. If the violation cannot be resolved, the volunteer will be asked to resign from the Volunteer Program. Such violations include, but are not limited to:

1. Inability to stay within the boundaries of a Volunteer role
2. Inconsistent Attendance
3. Failure to abide by the guidelines of confidentiality
4. Failure to communicate with the Volunteer Program when there is issue of concern and follow-up procedures
5. Breaking laws or condoning illegal behavior
6. Imposing values and/or religious views on a resident
7. Lending money and/or valuable items to a resident.
8. Any additional action deemed inappropriate by the Program Manager of Volunteer Resources.

I recognize that all client information is restricted to appropriate staff on a "need to know/to utilize" basis and that any authorized disclosure or discussion of client information on such a basis should occur in a discrete setting, preferably an office with the door closed.

I am aware that any action on my part inconsistent with the above policies and procedures or state law or this acknowledgement is cause for disciplinary action, which may include immediate termination from my volunteer position at Vista Maria.

\_\_\_\_\_  
Volunteer Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Volunteer Program Staff Signature \_\_\_\_\_  
Date

## **Tuberculosis Test Results Required**

Vista Maria is required to ensure that individuals having contact with our clients do not put them at risk. Therefore, a Tuberculosis (TB) test results are required to verify that individuals are not carrying the bacterium that causes TB.

If you have completed the TB skin test within the last year, you may submit a copy of the results. If you have taken a chest x-ray during the last 15 months, please submit a copy of the results.

**Question:** Where can I get TB skin test done?

**Answer:** You may go to your health care provider, medical care clinics or a public health clinic.

The name and locations of several service providers appear below. Vista Maria is not endorsing or recommending that you use these providers. If you elect to use a provider listed, please contact them to ensure the information listed is correct and that your personal requirements are met.

### **ACCESS**

6450 Schaffer

Dearborn, MI 48126

Phone: (313) 216-2230

Hours: Monday, Tuesday, Wednesday and Friday 9:00-12:00 & 2:00-4:00 p.m.

Cost: \$20.00

### **Health Division: Southfield**

27725 Greenfield Road

Southfield, Michigan, USA, 48076

Hours: Monday: 12:00 noon 8:00 p.m.

Tuesday & Wednesday: 8:30 a.m. 5:00 p.m.

Friday: 12:00 noon 5:00 p.m.

Phone: 248-424-7000

Cost: Free

### **Herman Keefer**

1151 Taylor Street

Detroit, MI 4820-1732

Phone: (313) 876-4826

Hours: Monday and Friday 8:00-3:00 p.m. Wednesday's 8:00-11:30 a.m.

Cost: \$10.00

### **Midwest Health System**

600 Woodbridge

Detroit, MI 48226

Phone: (313) 586-1433

Hours: 8:00-6:00 p.m. (Monday-Friday)

Cost: \$15.00 (\$13.00 if you say you are volunteering with Vista Maria)

### **Midwest Health System**

Detroit Metropolitan Airport

Building 533 E. Service Dr.  
Detroit, MI 48242  
Phone: (734) 941-1000  
Hours: 7:00-6:00 p.m. (Monday-Friday)  
Cost: \$15.00 (\$13.00 if you say you are volunteering with Vista Maria)

**Midwest Health System**

30150 Plymouth Rd.  
Livonia, MI 48150  
Phone: (734) 261-0100  
Hours: 8:00-6:00 p.m. (Mon-Fri)  
Cost: \$15.00 (\$13.00 if you say you are volunteering with Vista Maria)

**Midwest Health System**

8790 S. Telegraph Rd.  
Taylor, MI 48180  
Phone: (313) 295-2520  
Hours: Monday & Tuesday 8:00-7:00 p.m.  
Wednesday-Friday 8:00-5:30 p.m.  
Saturday 8:00-12:00 p.m.  
Cost: \$15.00 (\$13.00 if you say you are volunteering with Vista Maria)

**Midwest Health System**

5050 Schaefer  
Dearborn, MI 48126  
Phone: (313) 581-2600  
Hours: 24 hours  
Cost: \$15.00 (\$13.00 if you say you are volunteering with Vista Maria)

**Oakwood Health Care TB Clinic**

2001 Merriman  
Suite 300 Westland, MI 48185  
Phone: (734) 727-1130  
Hours: Monday and Wednesday 8:00-4:00 p.m. Friday's 8:00-12 noon  
Cost: \$10.00

# REQUEST FOR CENTRAL REGISTRY CLEARANCE

State of Michigan  
Michigan Department of Human Services

INSTRUCTIONS: Complete the following information and submit request to your **LOCAL** Department of Human Services (DHS) Office. See [www.michigan.gov/canregistryclearance](http://www.michigan.gov/canregistryclearance) for information on central registry clearance requests and how to contact the local DHS office.

I am requesting that DHS provide me with a Central Registry Clearance on myself.

Today's Date		
Name		
Birthdate	Social Security Number	
Current Mailing Address (Street No. and Name)		
City	State	Zip Code
Current Phone Number		
Other Names By Which Known		
_____		
_____		

**Indicate below how you want to receive the results of the central registry clearance:**

I would like the results mailed to the address on my picture identification.

**IF YOU WANT THE RESULTS MAILED TO YOU, PLEASE SUBMIT ALONG WITH THIS FORM, A COPY OF YOUR CURRENT PICTURE IDENTIFICATION. DUE TO CONFIDENTIALITY RESTRICTIONS, A COPY OF THE RESULTS WILL BE MAILED ONLY TO THE ADDRESS ON YOUR PICTURE IDENTIFICATION.**

I would like to pick up the results from the local DHS office.

**IF YOU ARE TEMPORARILY IN MICHIGAN AND THE ADDRESS ON YOUR PICTURE IDENTIFICATION AND YOUR TEMPORARY ADDRESS DO NOT MATCH, YOU MUST CHOOSE THIS OPTION.**

I would like the results mailed to:

Employer/Potential Employer

Volunteer Agency

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IF YOU ARE LISTED ON CENTRAL REGISTRY, THE RESULTS CANNOT BE MAILED TO AN EMPLOYER/POTENTIAL EMPLOYER OR VOLUNTEER AGENCY. RESULTS WILL BE MAILED TO YOU INSTEAD. A COPY OF YOUR CURRENT PICTURE IDENTIFICATION MUST BE PROVIDED.**

Signature of Requestor	Signature of DHS Staff Person Completing Request
<p>AUTHORITY: State P.A. 238 of 1975, MCL 722.627-722.627j RESPONSE: Voluntary PENALTY: Inappropriate release of this information is a misdemeanor.</p>	<p>Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.</p>

## LOCAL FIA OFFICES

<b>WAYNE COUNTY OFFICES</b>		
CFS - Central Operations 2929 Russell Detroit 313-396-0200	Grand River/Warren 5131 Grand River Detroit 313-361-7300	McNichols/Goddard 2400 E. McNichols Rd. Detroit 313-852-2300
CFS - North Central 13233 Hamilton Highland Park 313-852-1727	Gratiot/Seven Mile 14061 Lappin Detroit 313-372-6200	Medbury/Concord 6821 Medbury Detroit 313-267-0340
CFS - South Central 1801 E. Canfield Detroit 313-578-5100	Greenfield/Joy 8655 Greenfield Detroit 313-943-5200	Oakman/Grand River 4505 Oakman Blvd. Detroit 313-934-4400
CFS - Western Wayne 25350 Ecorse Rd Taylor 313-295-8000	Greydale/Grand River 17330 Greydale Detroit 313-387-7100	Redford 27260 Plymouth Rd. Redford 313-937-4200
Forest/Ellery 3606 E. Forest Detroit 313-267-0700	Hamtramck 2400 Denton Hamtramck 313-876-6304	Schoolcraft/Stansbury 14000 Schoolcraft Detroit 313-493-7400
Fort Wayne 6534 W. Jefferson Detroit 313-852-2187	Inkster 2700 Hamlin Inkster 313-277-4800	Taylor 22050 Pennsylvania, Taylor 734-281-8204
Fullerton/Jeffries 8000 Fullerton Detroit 313-934-7200	Lafayette 2000 W. Lafayette Detroit 313-963-6002	Tireman 8031 Tireman Ave. Detroit 313-934-5300
Glendale/Trumbull 396 Glendale Highland Park 313-852-2187	Lincoln Park 999 Fort Lincoln Park 313-389-0300	

## LOCAL FIA OFFICES

<b>OAKLAND COUNTY OFFICES</b>		
Baldwin Rd 1685 Baldwin Rd. Pontiac	Madison Heights 31170 John R Madison Heights	Walled Lake 195 Ladd Rd. Walled Lake
Bloomfield Hills Stoneridge E., Ste. 200 41000 Woodward Ave. Bloomfield Hills	Saginaw St 235 N. Saginaw Pontiac	

<b>MACOMB COUNTY OFFICES</b>		
Macomb County FIA - Central Administration 19700 Hall Rd., Ste. A Clinton Township	Sterling Hts. 44600 Delco Blvd. Sterling Heights	Warren 29600 S. Civic Center Blvd. Warren
Mt Clemens 21885 Dunham Rd. Clinton Township		

## ENTRY TO AND EXIT FROM CAMPUS (Sign In / Out Policy)

Security Officers stationed at the main entrance to Vista Maria will uniformly apply rules of authorized entry and exit.

The entrance gate will be operational at all times. The exit gate will be operational at all times except weekdays from 6 a.m. – 6 p.m.

1. **Vista Maria employees with tag.** Between the hours of 6 a.m. to 6 p.m., Monday – Friday, if the tag is visible, vehicle entry is allowed. At all other times employees with tags must follow the sign-in procedure. **We will not allow entry based on face / car recognition**
2. **Vista Maria employees without tag.** If no vehicle tag is visible, the vehicle will be stopped and official Vista Maria picture identification card must be shown.
  - A. With official picture identification and matching of the face of the employee to the picture on the card, **the employee must sign in before entering.**
  - B. If no vehicle tag and no Vista Maria identification card are presented:
    - i. The person must present picture identification such as valid driver's license or state-issued I.D. card.
    - ii. The employee's assigned work unit will be called to receive verification from the Supervisor on duty that the person is authorized to enter Campus. **The person must sign in.**
3. **Entry of non-employees** is restricted: this includes vendors, deliveries and all visitors.
  - A. The Security Officer will record their vehicle plate number, names of occupant(s) and destination. **The driver must sign in.**
  - B. Unless a Vista Maria employee has already granted authorization by altering the guards in advance, the Security Officer will call the destination or contact given to receive permission for entry. The visitor will wait until permission is given for entry. **If unable to make contact entry will be denied.** If permission is refused the visitor will be turned away.
4. **In cases of emergencies,** Vista Maria staff will **notify the guard** that emergency vehicles are expected and where the vehicles are needed.
5. **Agency vehicles must sign in and out at all times.** The "Agency Vehicle" sign in sheet must be used.
6. **Weekdays between the hours of 6 p.m. and 6 a.m. and all day on weekends and Holidays**
  - A. Everyone including staff must sign in and out of Campus.
  - B. **Staff can be dropped off at work but staff must have full identification. Staff will show their ID, sign in and then can be driven to their unit.**
  - C. All Agency vehicles must sign in and out, using the "Agency Vehicle" sheet.

Any concerns questions or comments should be directed to the Volunteer Services Manager.

_____	_____
<b>Signature</b>	<b>Date</b>

_____	_____
<b>Volunteer Program Staff Signature</b>	<b>Date</b>

**This Notice Describes How Medical Information About Your May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully.**

If you have any questions about this notice, please contact your Human Resources department.

#### **Who Will Follow This Notice**

This notice describes the medical information practices of Vista Maria group health plan (the "Plan") and that of any third party that assists in the administration of Plan claims.

#### **Our Pledge Regarding Medical Information**

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

#### **How We May Use and Disclose Medical Information About You**

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment (as described in applicable regulations).** We may use or disclose medical information about you to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions. **[Use where health plan is involved in rendering medical services.]**

**For Payment (as described in applicable regulations).** We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

**For Health Care Operations (as described in applicable regulations).** We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

**As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

#### **Special Situations**

**Disclosure to Health Plan Sponsor.** Information may be disclosed to another health plan maintained by Vista Maria for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to Vista Maria personnel solely for purposes of administering benefits under the Plan.

**Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the hospital; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

#### **Your Rights Regarding Medical Information About You**

You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to [Employer contact]. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to Human Resources. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list of accounting of disclosures, you must submit your request in writing to Human Resources. Your request must state a time period which may not be longer than six years and may not include dates before April 2003 (or 2004 for small group health plans). Your request should indicate in what form you want the list (for example, paper or electronic). The first accounting you request within a 12 month period will be free. For additional requests, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Human Resources. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

We have the right to deny these requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

**Changes to This Notice**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Plan website. The notice will contain on the first page, in the top right-hand corner, the effective date.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact [Insert the name, title, and phone number of the contact person or office responsible for handling complaints. This should be the same person or department listed on the first page as the contact for more information about this notice.]. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

**Other Uses of Medical Information**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

**EMPLOYEE RECEIPT CERTIFICATION**

I HAVE READ AND RECEIVED A COPY OF THIS HIPPA NOTIFICATION. I FURTHER UNDERSTAND THAT IF I NEED CLARIFICATION OR HAVE ANY QUESTIONS; I SHOULD CONTACT A REPRESENTATIVE FROM THE HUMAN RESOURCES DEPARTMENT AT VISTA MARIA.

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNED NAME