



How to complete the Volunteer Intern 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.

Volunteer Interns 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 Intern 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.
 - **Current Employment Contact Information**
 - **Employment History**
 - **Education Information**
 - **Volunteer Availability**
 - **Criminal History Record Check Consent and Sex Offender Registry** – Please include 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 carefully and sign
 - **Confidentiality and Policy Acknowledgement** – Please read carefully and sign
 - **Entry and Exit from Campus Acknowledgement**—Please read carefully and sign
 - **HIPPA Acknowledgement**—Please read carefully and 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 bringing it to your first interview at Vista Maria, along with your driver's license. Vista Maria staff will submit this form, along with a copy of your photo ID, to DHS. 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. **Other Notes to Consider:**

- All of the above **MUST** be submitted before starting your internship.
- Vista Maria accepts interns based on the availability of intern supervisors within the agency. This may vary by semester.
- Placement is **NOT** guaranteed.
- Placement is unpaid.
- Please see Vista Maria's website for application periods per semester:
www.vistamaria.org/get-involved/volunteer/internship
- Student interns will also be asked to notify the Volunteer Resources department any requirements implemented by their school's internship programs such as certain supervisory degree levels, number of direct client hours, and total number of hours needed to complete the internship. This will ensure correct and fruitful placement within our agency.

Vista Maria Volunteer Intern 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

Date of Application: _____

Name: _____ Sex: Male Female

Applicant Address: _____

City, _____ State, _____ ZIP: _____

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:

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

Describe your interest in being an intern at Vista Maria:

Describe any volunteer work you have done in the past:

What are your motivations to becoming an intern at Vista Maria?

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

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

If yes, please explain:

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:

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:

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: _____

Current Employment Information

Name of Employer: _____

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

Employment History (Please list work experience within the last 5 years, attach resume if needed)

1) Name of Employer: _____ Phone: _____

Address, City, State, ZIP: _____

Date of Employment: _____

2) Name of Employer: _____ Phone: _____

Address, City, State, ZIP: _____

Date of Employment: _____

3) Name of Employer: _____ Phone: _____

Address, City, State, ZIP: _____

Date of Employment: _____

4) Name of Employer: _____ Phone: _____

Address, City, State, ZIP: _____

Date of Employment: _____

Education Information

School: _____ Degree/Major: _____

Availability to Complete Your Hours

Please indicate days and times you are available by providing an "x" in the appropriate boxes. Please note that evening and weekend hours for completing internship hours are *very* limited.

	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.							

Criminal History Record Check Consent/Sex Offender Registry

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

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 & Mediation Skills</i>	1	2	3	4	5
e. <i>Knowledge of & 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: _____

Reference Information

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 & Mediation Skills</i>	1	2	3	4	5
e.	<i>Knowledge of & 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: _____

Reference Information

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 & Mediation Skills</i>	1	2	3	4	5
e. <i>Knowledge of & 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

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

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

<hr/>	
Volunteer Program Staff Signature	Date

Confidentiality and Policy Acknowledgement

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

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

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 volunteers with tag.** If the tag is visible, vehicle entry is allowed. **We will not allow entry based on face / car recognition.**
2. **Vista Maria volunteers 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 volunteer to the picture on the card, **the volunteer 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 volunteer’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 unknown volunteers** 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 volunteer 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. Volunteers can be dropped off onto campus, but they must have full identification. Volunteers will show their ID, sign in and then can be driven to their unit.

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

PLEASE SIGN AND DATE

_____	_____
Signature	Date

_____	_____
Volunteer Program Staff Signature	Date

This Notice Describes How Medical Information About You 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 **PLEASE SIGN**



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.

The test will be performed with a small injection. It will cause a pale elevation of the skin (6 to 10mm in diameter). The reaction should be measured by millimeters of the induration (palpable, raised, hardened area or swelling), not by redness. The test reaction should be read between 48 and 72 hours after administered. After that time frame, a new test would need to be administered.

Classification of the Tuberculin Skin Test (TST) Reaction		
<p>An induration of 5mm or more is considered positive for persons who:</p> <ul style="list-style-type: none"> • Have HIV • Had recent contact with a person with TB • Had organ transplants • Are immunosuppressed for other reasons 	<p>An induration of 10mm or more is considered positive in:</p> <ul style="list-style-type: none"> • Immigrants from high-prevalence countries during the last 5 years • Injection drug users • Residents of high-risk congregate settings • Persons with high risk clinical conditions • Children under 4 • Adolescents/children/infants exposed to high-risk adults. 	<p>An induration of 15mm or more is considered positive in any persons.</p>

False-Positive Reactions	False-Negative Reactions	Boosted Reactions
<p>Some persons may react to the TST even though they are not infected. Causes may include:</p> <ul style="list-style-type: none"> • Infection with nontuberculosis mycobacteria • Previous BCG vaccination • Incorrect administration • Incorrect reaction interpretation • Incorrect bottle of antigen used 	<p>Some persons may not react to the TST even though they are infected. Causes may include:</p> <ul style="list-style-type: none"> • Weakened immune system • Recent TB infection(within 8-10 weeks of exposure) • Old TB infection(many years) • Young age(less than 6 months old) • Overwhelming TB disease • Some viral illnesses (measles or chicken pox) • Incorrect administration • Incorrect reaction interpretation 	<p>In some persons who are infected, the ability to react to it may wane over time.</p> <p>This can produce a false-negative reaction. It also may stimulate a positive reaction in subsequent tests.</p> <p>Giving a second test after the initial test is called Two-Step Testing.</p>

Can TSTs Be Given To Persons Receiving Vaccinations?

Vaccination with live viruses may interfere with TST reactions. For persons scheduled to receive a TST, testing should be done as follows:

- Either on the same day as the vaccination or 4-6 weeks after the administration of the live-virus vaccine.
- At least one month after smallpox vaccination

Previous Results and Locations for TB Testing

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 a 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, 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 p.m. & 2:00-4:00 p.m.

Cost: \$20.00

Ann Arbor Urgent Care

1000 E. Stadium Blvd., Suite 1

Ann Arbor, MI 48104

Phone: (734) 769-3333

Hours: Monday-Friday 9:00 a.m.-10:00 p.m. Saturday and Sunday 9:00 a.m.-7:00 p.m.

Cost: \$35.00

Canton Urgent Care

43033 Ford Rd.

Canton, MI 48187

Phone: (734) 844-2296

Hours: Sunday-Saturday 10:00 a.m.-10:00 p.m.

Cost: \$45.00

Locations for TB Testing, Continued

Detroit Department of Health and Wellness Promotion

IPH Northend, 8904 Woodward Avenue

Detroit, MI 48202

Phone: (313) 309-6720

Hours: Every day except Thursday's 8:00-5:00 p.m.

Cost: \$10.00

Health Division: Southfield

27725 Greenfield Road

Southfield, MI 48076

Hours: Monday: 12:00-8:00 p.m., Tuesday & Wednesday: 8:30 a.m.-5:00 p.m., Friday: 2:00-5:00 p.m.

Phone: 248-424-7000

Cost: \$8.00

Midwest Health System

Detroit Metropolitan Airport

Building 533 E. Service Dr.

Detroit, MI 48242

Phone: (734) 941-1000

Hours: 8:00-4:00 p.m. (Monday-Friday)

Cost: \$20.00

Midwest Health System

30150 Plymouth Rd.

Livonia, MI 48150

Phone: (734) 261-0100

Hours: 8:00-6:00 p.m. (Monday-Friday) Must be there by 5:30 p.m. to get it done.

Cost: \$20.00

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: \$20.00

Midwest Health System

5050 Schaefer

Dearborn, MI 48126

Phone: (313) 581-2600

Hours: 24 hours

Cost: \$20.00 (\$15.00 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 8:00-4:00 p.m. Wednesday 8:00-3:00 p.m. Friday 8:00-12 noon

Cost: \$20.00

Updated January 26, 2015

CENTRAL REGISTRY CLEARANCE REQUEST

Michigan Department of Human Services

INSTRUCTIONS:

- An enlarged and clear copy of individual's photo identification must be attached.
- For Michigan employers, individuals and volunteer agencies, submit this request to the local County Department of Human Services. To obtain the address and fax number of your local county DHS, access www.michigan.gov/dhs -> Inside DHS.
- For individuals seeking clearance on themselves, the results will be sent to the address on the picture identification provided.
- Outstate Children's Protective Services workers, law-enforcement, and court officials fax request to 517-241-7047 (Outstate only) on agency letterhead with cover sheet.
- All fields must be completed for processing.

COPY PHOTO ID HERE AND RETAIN A COPY FOR YOUR RECORDS
OR ATTACH A CLEAR COPY OF YOUR ID ON A SEPARATE PAGE

SECTION 1 INFORMATION ON PERSON BEING CLEARED

Name: First, Middle, Last	AKA (Also Known As) (Maiden Name)	Social Security Number	Signature Required for individual being cleared
Address	Phone Number	Date Of Birth	

SECTION 2 REQUESTOR INFORMATION

Please Check Appropriate Box

Child Welfare Agency I would like to pick up my results in _____ county MI _____
 Individual
 Law-Enforcement/Dept of Corrections
 Prosecuting Attorney/Court (please provide docket number if available)

Please Check Appropriate Box

Employer
 Volunteer Agency
 Out-of-State Adoption and Foster Home Screening
 Other

Name of Employer/Volunteer Agency/Individual Vista Maria		Name of CPS/Law-Enforcement or Court	
Name Volunteer Resources		Title	
Address 20651 W. Warren Ave, Dearborn Hts, MI 48127		City State Zip Code	
Phone 313-271-3050	Fax	E-mail	Date