LINK ASSOCIATES

1452 - 29th Street West Des Moines, IA 50266 Phone: 515 262-8888

Fax: 515 225-1631

Dear Volunteer Applicant:

Enclosed is everything needed to complete your application for volunteering at Link Associates. We are anxious to meet with you and share the vast volunteer opportunities our agency has to offer. To process your application, the following must be completed and/or occur:

- 1. The highlighted areas on EACH form must be completed and <u>signed</u>.
- 2. Volunteering at Link Associates is contingent upon:
 - a. Link receiving two (2) acceptable references; one personal (no relatives) and one employer/school/or volunteer supervisor

(please fill out all three reference forms to insure we receive the minimum of two)

- b. An acceptable background check including abuse and criminal records
- c. An acceptable driving record (under aged youth are exempt from this requirement)
- d. Health screening with Link's agency nurse (to be scheduled upon completion of a, b and c above
- e. TB test (to be scheduled with the agency nurse) OR documentation of a TB screening within the past twelve months

We thank you for your interest in volunteering at Link Associates. Please do not hesitate to call 262-8888 with any questions you may have about the application, process, or Link Volunteer Program.

We look forward to meeting with you soon.

Thank you for choosing to make a difference in someone's life!

LINK ASSOCIATES

Volunteer Application

| PERSONAL Name: First Middle Initial | | | | |
|---|---------------------------------|--------|----------|---------|
| Namo: | | | | |
| ivaine. | | | | |
| First Middle Initial | | | Last | |
| Address: Street City | | | | |
| | | | Zip code | |
| Phone: Home()Work() | | Cell(|) | |
| Email: | | | | |
| Birthdate: Social Security | | | | |
| Emergency Notification and Phone: | | Dhara | | |
| Name | | Phone | | |
| EMPLOYMENT/EDUCATION | | | | |
| Employer: | nployer: Phone: | | | |
| Highest level of education completed: | | | | |
| School/college: | chool/college: Course of study: | | | |
| AVAILABILITY FOR VOLUNTEER SERVICE | | | | |
| Places write your available bours in the appropriate boy/os | \ | | | |
| Please write your available hours in the appropriate box(es) Monday Tuesday Wednesday Th | | Friday | Saturday | Sunday |
| Morning Tuesday Wednesday III | arouay | Tilday | Jataraay | Cariaay |
| Afternoon | | | | |
| Evening | | | | |
| INTERESTS AND SKILLS List hobbies, skills, or special trainings that would help you | as a volunto | eer: | | |
| List any prior volunteer experience: | | | | |
| List any experience you have with persons with disabilities: | | | | |
| What type(s) of volunteer work are you interested in doing? | | | | |

REFERENCES/BACKGROUND

Please list two(2) references that we may contact including one personal and one work/school/volunteer: (Please do not include relatives)

| 1. | Name: | | Last | Relationship Phone: |
|--|--|---|--|--|
| | | | | |
| 2. | Name: | | Last | Relationship Phone: |
| | | | | |
| Explai | n: | Yes | No | adult or child abuse in this state or any other? crime other than a minor traffic violation in Iowa |
| | n: | | | om consideration of volunterring with Link Associates. |
| | | | APPLICANT STATEM | <u>ENT</u> |
| policies and co comple statem authori work, e others will cor | s and procedu mplete to the ete, I may not I ents contained ze my present employment, v from all liabilit nduct a child a | res. By signing best of my know be eligible to be d in this applicat and any past olunteer history of providing the buse/criminal research. | g below, I certify that the answ wledge. I acknowledge that if a Link Associates volunteer. It ion for my volunteer services employers and volunteer organ, or character to Link Association in good faith arecord check on my backgroun | d comply with all rules, regulations and agency ers and information set out on this form are accurate any answer or information is not accurate and I authorize Link Associates to investigate all, as well as my character and qualifications. I nizations to release any information regarding my tes. I also release those employers, references and without malice. I understand that Link Associates d. I waive any right that I may have to inspect any ntified by me on this application. |
| Signat | ure | | | Date |
| Pleas | e submit ap _l | plications to: | Volunteer Coordinate | or |

Link Associates 1452 – 29th St West Des Moines, IA 50266 Phone: 515 262-8888; fax: 515 225-1631



Iowa Department of Human Services

Authorization for Release of Child and Dependent Adult Abuse Information

This form must be used to authorize release of child or dependent adult abuse information when the person requesting the information does not have independent access to it under lowa law. Complete a separate form for each person for whom information is requested and email to dhsabuseregistry@dhs.state.ia.us, or fax to (515) 564-4112, or mail to the lowa Department of Human Services, Central Abuse Registry, P.O. Box 4826, Des Moines, IA 50305.

Please specify which abuse registry you are requesting by checking the appropriate box below:

| Please specify which abuse registry you are requ ☐ Child Abuse Registry ☐ Dependence | | checking the Abuse Regis | | oelow: ⊠ Both | | | |
|--|------------|-----------------------------|--------------------|-----------------------------|------------------------------|--|--|
| Please specify your preferred method of respor ☐ Address ☐ Fax | nse by che | ecking a box | | e information ir □ Email | Section 1. | | |
| Section 1: To be completed by the person of | or agency | / requesting | g the information |), | | | |
| Requester: Last First | | gency Name | | | Telephone Number | | |
| Link Associates Address | | | | | (515) 262-8888 Fax Number | | |
| 1452 29 th Street | | | | (515) 225-1631 | | | |
| City State West Des Moines IA | | | Zip Code 50266 | Email | | | |
| List the name and address of the person whose ir | nformation | n is being req | juested: | | | | |
| Name (last, first, middle) | | | Birth Date | Social Sec | Social Security Number | | |
| Address | City | | County | State | Zip Code | | |
| List maiden name, previous married names, and a | any alias: | | 1 | | | | |
| What is the purpose of your request for child or de Employment | ependent | adult abuse | information? | | | | |
| I have read and understand the legal provisions to the second page of this form. | or handlin | g child and d | lependent adult ab | use informatior | n which is printed on | | |
| Signature of Requestor | | | | Date | Date | | |
| Section 2: To be completed by the person authorizing the Department of Human Services to release their child or dependent adult abuse information. | | | | | | | |
| I understand that my signature authorizes the requester to receive information to verify whether I am named on the Child Abuse or Dependent Adult Abuse Registry as having abused a child (lowa Code section 235A.15) or dependent adult (lowa Code section 235B.6). To the best of my knowledge, the information contained in Section 1 of this form is correct. | | | | | | | |
| Signature of Person Authorizing | | | | Date | | | |
| Section 3: To be completed by the Central Abuse Registry or designee. | | | | | | | |
| □ The person whose information is being requested is listed on the Child Abuse Registry as having abused a child. □ The person whose information is being requested is not listed on the Child Abuse Registry as having abused a child. □ The person whose information is being requested is listed on the Dependent Adult Abuse Registry as having abused a dependent adult. □ The person whose information is being requested is not listed on the Dependent Adult Abuse Registry as having abused a dependent adult. □ This request for information is denied because the form is incomplete. | | | | | | | |
| Signature of Registry Staff or Designee | | | | Date | Date | | |
| Comments | | | | | | | |

LEGAL PROVISIONS FOR HANDLING CHILD AND DEPENDENT ADULT ABUSE INFORMATION

Redissemination of Child and Dependent Adult Abuse Information (Iowa Code sections 235A.17 and 235B.8)

A person, agency, or other recipient of child or dependent adult abuse information shall not redisseminate (release) this information, except that redissemination is permitted when **ALL** of the following conditions apply:

- ♦ The redissemination is for official purposes in connection with prescribed duties or, in the case of a health practitioner, pursuant to professional responsibilities.
- ♦ The person to whom such information would be redisseminated would have independent access to the same information under lowa Code sections 235A.15 or 235B.6.
- ♦ A written record is made of the redissemination, including the name of the recipient and the date and purpose of the redissemination.
- The written record is forwarded to the Central Abuse Registry within 30 days of the redissemination.

Criminal Penalties (Iowa Code sections 235A.21 and 235B.12)

A person is guilty of a criminal offense when the person:

- Willfully requests, obtains, or seeks to obtain child or dependent adult abuse information under false pretenses, or
- ♦ Willfully communicates or seeks to communicate child or dependent adult abuse information to any agency or person except in accordance with Iowa Code sections 235A.15, 235A.17, 235B.6, and 235B.8, or
- ♦ Is connected with any research authorized pursuant to Iowa Code sections 235A.15 and 235B.6 and willfully falsifies child or dependent adult abuse information or any records relating to child or dependent adult abuse.

Upon conviction for each offense, the person is guilty of a serious misdemeanor punishable by a fine or imprisonment.

Any person who knowingly, but without criminal purposes, communicates or seeks to communicate child or dependent adult abuse information except in accordance with lowa Code sections 235A.15, 235A.17, 235B.6, and 235B.8 is guilty of a simple misdemeanor punishable, upon conviction for each offense, by a fine or imprisonment.

Any reasonable grounds for belief that a person has violated any provision of Iowa Code Chapters 235A or 235B shall be grounds for the immediate withdrawal of any authorized access that person might otherwise have to child or dependent adult abuse information.

Link Associates HR-1: OIG and SAMS Excluded Individuals Release Form and Waiver for Criminal History

As a participant in Federal Medicare, Federal Medicaid and other Federal Health and Human Services Programs, Link Associates is required to check the exclusion lists.

Link Associates screens all new employees upon hire and current employees on an on-going basis, on both OIG and SAMS. Link is required to check all names each employee has ever gone by or been known by. To assist Link in compliance with these requirements, please provide your current name and all additional names you have gone by or been known by in the past, including maiden names, married names, hyphenated names and any alias you have used.

PLEASE PRINT CLEARLY

Current

First Name

Current M I

Current

Last Name

Former Former Former MI/s Last Name/s First Name/s **Employee Acknowledgement:** Any and all names I have used have been provided on this form and are true and complete and subject to validation by Link Associates. I am aware that any deliberate falsification, including withholding information on this document constitutes grounds for rejection of my application or dismissal if I am hired. I agree to notify Link Associates of any future name changes. I understand I am to notify Link Associates if at anytime during my employment I become an excluded individual or entity on either the OIG or SAMS exclusion lists. I also understand that my employment and continued employment with Link Associates' is contingent upon my on-going cooperation with this process and verification that I am not an excluded individual or entity on either the OIG or SAMS exclusion lists. I hereby give permission for the above requesting official to conduct an lowa criminal history record check with the Division of Criminal Investigation (DCI). Any criminal history data concerning me that is maintained by the DCI may be released as allowed by law. **Employee's Current Street Address** City, Zip Code **Employee Social Security Number** Gender / Sex Date of Birth **Employee Signature Date Signed**

Link Associates TR-3: Authorization for Confirmation of Driving Record

| Applicant / Employee: | Date of Request: | | |
|---|--|-----------------------------|--|
| Social Security No: | | | |
| Driver's License No: | State: | | |
| Expiration Date: | | | |
| Vehicle Insurance Policy | | | |
| The Agency does not provide any liability or physical damage insurance for vehicles owned by sinsurance on file if employees or volunteers are transporting consumers in their own vehicle, or vehicle. The Agency recommends employees or volunteers maintain auto liability limits of at leaproperty damage per occurrence. Employees or volunteers are not to transport consumer(s) in | will be conducting Agency related business ast \$300,000 combined single limit bodily injanother individual's vehicle. | in their own ury and | |
| Staff shall be reimbursed at the rate indicated in the employee handbook for their business use including insurance, for the operation of their personal auto for agency business. The Agency volunteer may have to pay for physical damage loss to their vehicle while on agency business. vandalism or accidents to employee or volunteer personal vehicles that may occur during work acconsumer homes, and consumer employment sites. | vill not pay for any deductible amount that th The Agency has no insurance and will not p | e employee or ay for any | |
| I give my permission for Link Associates to verify my driving record with the Iowa Department of policy excerpt and agree to abide by the policy. I further confirm my answers to the driving recomy knowledge and am aware that any deliberate falsification, including withholding information dismissal if I am hired. | ord questions below, are true and complete t | o the best of | |
| | Applicant / Employee | | |
| | | | |
| Driving Record Questions: | Circ | Circle One | |
| 1. Do you have reliable transportation for a maximum of 4 occupants? | YES | NO | |
| 2. Do you have a valid Driver's License? | YES | NO | |
| 3. Do you have proof of auto insurance? | YES | NO | |
| 4. Have you been involved in a vehicle accident in the last 5 years? If YES, were you at fault? | YES | NO | |
| 5. Have you had any speeding or moving violations in the last 5 years? If YES, Please provide 6. Have you had your license suspended or revoked in the past 5 years? | details. YES YES | NO NO | |
| 7. Have you received a DUI/OWI in the past 5 years? | YES | NO | |
| 1. Trave you received a Donowi in the past o years: | 120 | 110 | |
| Details: | | | |
| | | | |
| | | | |
| | | | |
| Results / Comments (attach MVR report): | | | |
| Toodito , Commente (attach meri report). | | | |
| | | | |
| | | | |
| | | | |
| Date Signature of Staff Comp | leting | | |