



## ADULT VOLUNTEER APPLICATION

Date of Application \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

**We will need a copy of your driver's license to run a background check.**

**If you are planning to drive for Meals on Wheels we will also need a copy of your car insurance.**

Availability (Check all that apply)	A.M.	P.M.					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	

How did you learn about our Volunteer Program

\_\_\_\_\_  
\_\_\_\_\_

Do you know anyone employed at Grand River Health?

\_\_\_\_\_

Have you ever been employed by or volunteered for GRH before? YES NO

If yes, when and which site?

\_\_\_\_\_

Special Skills: \_\_\_\_\_

**References**

Please List two references

1. \_\_\_\_\_  
Name Phone

2. \_\_\_\_\_  
Name Phone

**Emergency Contact Information:**

\_\_\_\_\_  
Name/Relationship Address Phone

By signing this application, I am acknowledging that I understand the guidelines of Grand River Health's Volunteer Program and agree to the following:

- Yearly TB paperwork
- Will take the drug screen
- Blood draw for medical screenings
- I have read, understand and will abide by the Oath of Confidentiality.
- Background check
- Will comply with all Colorado State requirements including wearing a seatbelt, following the rules, licensure, registration, and insurance.
- Provide a copy of your driver's license
- If you are planning to drive for Meals on Wheels we will also need a copy of your current car insurance.
- I agree to commit a minimum of 48 hours to volunteering at Grand River Health
- A flu shot is required between Nov. 1 - April 1 (This is provided free of charge to our volunteers)

**VOLUNTEER APPLICANT**

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

Email address that background check can be sent to: \_\_\_\_\_

We look forward to working with each of you.  
If you have any questions please feel free to call or e-mail.

**Kaaren Peck**  
Volunteer Services/Grand River Meals on Wheels  
kpeck@grhd.org  
970.625.6423 | 970.625.7366 fax 501 Airport Road |  
P.O. Box 912 | Rifle, CO 81650

**Dee Warwick**  
Volunteer Services Assistant  
dwarwick@grhd.org  
970.625.6215 | 970.625.7366 fax  
501 Airport Road | P.O. Box 912 | Rifle, CO 81650



## **ADULT ORIENTATION GRAND RIVER HEALTH POLICIES AT A GLANCE**

### **Appearance: professional (and conservative)**

You may just have a 5-minute encounter with a patient and you are to shine and put forth a professional, respectful, caring image.

- Wear your name badge and volunteer vest at all times (it is important that you are not mistaken for an employee!)
- No open toed shoes when in patient care areas.
- No denim, not even skirts, shirts or jumpers.
- Nails and makeup – conservative. No intense perfumes (may trigger asthma).
- Hair: neat, clean and away from your face. If you are in the kitchen, you will need a hairnet (provided) or a hat.
- No t-shirts, sweatshirts, spaghetti strap, backless shirts or dresses. No slogans or printed messages on shirts (logos are fine). Scrubs are great and easy to clean. No holes, tears, too tight or showing of skin.
- No shorts; capris and longer skirts or dresses or skorts are fine.(all of which need to be only 5 inches above knee).
- No lip / mouth / nose piercings (ears are fine).
- No unfriendly tattoos

### **Cell Phones / Electronics:**

No cell phone use while on duty (no texting or talking); leave it at home, in the car, etc. You may use your phone/I-pods, etc. in the cafeteria or outside during breaks and meals.

### **Customer Service & Confidentiality:**

You are here to make someone's day:

- Smile – it goes along way
- Greet / welcome, ask, "How may I help you?"
- Frequent thank you's. Politeness is key; remember, you represent Grand River Health!
- Remember and keep your oath of confidentiality when you leave GRH.
- You are invited to attend the periodic Customer Service Training – see your supervisors for dates.

### **Sign – In Procedure:**

Please sign in and out for every shift in the Volunteer / binder found at the Customer Service front desk (ask Customer Service Representative for help if need be).

### **Punctuality and Absences:**

Please be punctual to your shifts. Call if an unexpected absence (Dee 625-6215) is necessary. We rely on you! You are important and your presence and work will be missed! Planned vacations are expected. Please let me know your schedule changes.

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**Parking:**

Please park in the South Employee parking lot. It is important that we save the closer parking spaces near the entrances for our patients. If you are volunteering at the Grand River Office Plaza, you may park in that parking lot.

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**Perks:**

For every 4-hour shift, you are entitled to a meal in our great cafeteria. You should be wearing your name badge and volunteer vest and you can pick up your meal ticket at the customer service desk. The meal will be charged to the Volunteer program.

**I have read and understand Grand River Health's Volunteer Policies and agree to comply. Any volunteer who does not meet the standards of these policies will be required to take corrective action, which may include leaving the premises. Continued refusal to comply with these policies will result in further disciplinary action and may subject the volunteer to suspension and possible dismissal.**

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Printed Name

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Signature

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Volunteer Service's Signature

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Date



AGREEMENT, AUTHORIZATION, AND CONSENT FOR RELEASE OF BACKGROUND INFORMATION

PLEASE TYPE OR PRINT

I, \_\_\_\_\_
LAST NAME FIRST NAME MIDDLE NAME (PLEASE INCLUDE Jr., SR., II, III Ect)

understand that In conjunction with my application for employment, work to be performed under contract, promotion, volunteer position, reassignment, and/or retention ("Work"), Grand River Hospital District will use the services of an outside agency to research and verify the Information I have provided on my application for employment Including my personal background, character, professional standing, work history and qualifications. This agency will provide a written report of its findings to Grand River Hospital District. Grand River Hospital District uses Sterling, a consumer-reporting agency, as an agent to perform Its Employment related background Investigations.

Sterling will utilize various sources of Information It deems appropriate Including but not limited to: criminal conviction records, current and former employers, department of motor vehicle records, military records, credit reporting agencies, education records, professional and personal references and workers compensation records Including any and all Injuries In compliance with the Americans with Disabilities Act. I agree, authorize and consent to the release and disclosure of any and all Information including but not limited to the above to Grand River Hospital District, and Sterling.

I agree, authorize and consent to the procurement of a Consumer Report and/or an Investigative Consumer Report and understand that it may contain information about my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. This authorization in original or copy form shall be valid for my term of Work from the date indicated next to my signature. According to the Fair Credit Reporting Act, I will be notified by Grand River Hospital District If Work Is denied because of Information obtained from a Consumer Reporting Agency. Additionally, I understand that If requested within 60 days, I will be given a full and accurate disclosure as to the nature and iibuslan9e of !'Ill Information provided to Grand River Hospital District. I further understand that I may request a copy of the report, and that when doing so, proper Identification will be required and I should direct my request to: Sterling, 1 State Street, New York NY 10004 (877) 424-2457, www. sterlinginfosystems.com. I understand that residents of all states will automatically receive a copy of the report if an adverse action Is taken regard-ing the employment application, or upon request as outlined herein.

[ ] CHECK THIS BOX IF you are applying for work with a California, Minnesota or Oklahoma based employer and you would like a copy of your Consumer Report if one is prepared in the investigation of your background. CA Codes 1785.20.5 & 1786.16(a)(5)(b)(1), MN Code 13C Subdi- vision 2, OK Code 24 O.S. §148

LAW ENFORCEMENT AGENCIES AND OTHER ENTITIES FOR POSITIVE IDENTIFICATION PURPOSES REQUIRE THE FOLLOWING INFORMATION WHEN CHECKING PUBLIC RECORDS. IT IS CONFIDENTIAL AND WILL NOT BE USED FOR ANY OTHER PURPOSES. PLEASE PRINT CLEARLY.

Signed \_\_\_\_\_ Today's Date \_\_\_\_\_
Name as it appears on your driver's license \_\_\_\_\_ Position Applied For \_\_\_\_\_
Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Drivers License Number \_\_\_\_\_ State \_\_\_\_\_
Email \_\_\_\_\_
Other names you ave used, or are also known as, including maiden name, name changes and any aliases:
-YOUR CURRENT ADDRESS-
Current Address: Street Apt.# City State Zip
Former Address: Street Apt.# City State Zip
Former Address: Street Apt.# City State Zip
Former Address: Street Apt.# City State Zip

# BELOW IS A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT.

Please read and scroll to the bottom of the page to sign this document.

Para informacion en espanol, visite [www.ftc.gov/credit](http://www.ftc.gov/credit) o escribe a la FTC Consumer Response Center, Room 130-A-600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

## A Summary of Your Rights Under the Fair-Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. For more information, including information about additional rights, go to [www.ftc.gov/credit](http://www.ftc.gov/credit) or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

**You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment - or to take another adverse action against you - must tell you, and must give you the name, address, and phone number of the agency that provided the information.

**You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identity theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within 60 days.

In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See [www.ftc.gov/credit](http://www.ftc.gov/credit) for additional information.

**You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

**You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See [www.ftc.gov/credit](http://www.ftc.gov/credit) for an explanation of dispute procedures.

**Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

**Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than 7 years old, or bankruptcies that are more than 10 years old.

**Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

**You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to [www.ftc.gov/credit](http://www.ftc.gov/credit).

**You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).

**You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

**Identity theft victims and active duty military personnel have additional rights.** For more information, visit [www.ftc.gov/credit](http://www.ftc.gov/credit).

**States may enforce the FCRA and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General, Federal enforcers are:**

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer response Center - FCRA Washington, DC 20580 1-877-382-4357
National banks. Federal branches/agencies of foreign (word "national" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System members banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 202-452-3693
Saving associations and federally chartered saving banks (word "federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 800-842-6929
Federal credit unions (word's "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Ste 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or interstate Commerce Commission	Department of Transportation Office of Financial Management Washington, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act. 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 202-720-7051

**I acknowledge receipt of the preceding "Summary of Rights" by checking this box.**

You will find a print option at the bottom of this page.



HOSPITAL SERVICES | FAMILY MEDICINE | WOMEN'S HEALTH | INTERNAL MEDICINE | SPECIALTY SERVICES  
MENTAL HEALTH SERVICES | LONG TERM CARE | OCCUPATIONAL HEALTH SERVICES | SCHOOL BASED HEALTH

## OATH OF CONFIDENTIALITY

Confidentiality is a patient/resident right. Breach of confidentiality is unacceptable and will not be tolerated. Any employee of GRH that divulges or inappropriately looks up Health Information on a patient is subject to immediate suspension and possible termination pending investigation results.

Information may be given to another employee or member of the medical staff when it is necessary to do so in the performance of job duties.

I, \_\_\_\_\_ agree not to divulge, publish or otherwise make known to unauthorized persons or the public any information obtained in the course of my work at Grand River Health.

Confidential information shall include, but is not limited to the following:

- Any medical information concerning the patient's history of illness, condition, diagnosis, treatment, prognosis, and/or visit history etc.
- Any insurance or financial information regarding the patient or patient representatives.
- Any information acquired about a patient or patient's family due to the employee's association with Grand River Health.
- Any Grand River Health information about departmental operations, projects, studies or research.

The Colorado Computer Crime Statute, CRS SS 18-5.5-1011, et seq., is designed to punish and deter computer crime. In compliance with the law, the district prohibits unauthorized access to its computer system, either directly or by network or telephone. An individual who does not have a legitimate password will be held to know that access is unauthorized. The sharing of computer passwords is strictly prohibited. The District prohibits the destruction or corruption of electronically stored or processed data. Persons who violate these rules will be prosecuted to the full extent of the law.

This oath applies if you are on duty, off duty, or on your free time and after you have left the employment of Grand River Health.

If you have questions regarding what is considered confidential information, please ask your supervisor, Health Information Management/Privacy Officer, Information Technology/Security Officer.

I have read the above information and understand its contents and agree to abide by the rules of confidentiality. I understand that failure to maintain confidentiality will result in disciplinary actions that may include immediate termination. I also understand that if I discuss confidential information inappropriately, that I could be held civilly liable and personally liable for any damaged persons.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



## MEDIA RELEASE

I, \_\_\_\_\_, hereby authorize Grand River Hospital District, referred to herein as GRHD, to disclose the following types of information to the general public for GRHD's marketing purposes.

- My name and other personal identifying information.
- Photographs and / or audio or video recordings of me.
- My artwork, poetry, music or other creative materials.

I grant GRHD the right to use this information in educational materials and presentations, advocacy public/community relations, promotional materials and similar purposes. I understand that GRHD may edit my information and that I do not have the right to approve the final production before it is released.

I understand and authorize that such disclosure may be in multiple media formats including, but not limited to, audio, video and print, and may include distribution through any physical, electronic and/or digital means including Internet postings (e.g., GRHD's website or Facebook page).

I understand such disclosure may identify me as a visitor, patient, employee or volunteer to any and all of GRHD's locations and/or services.

My ability to obtain services does not depend on signing this authorization. Copies of this form may be used in lieu of the original. GRHD cannot guarantee that recipients of your information will not further disclose to another party and that the information may no longer be protected.

This authorization may be revoked at any time by writing to: Director of Community Relations, Grand River Hospital District 501 Airport Road, Rifle CO 81650. Unless revoked, this authorization has no expiration date and will be placed on file in the Community Relations Department.

I hereby voluntarily and knowingly forever release GRHD, and its directors, officers, employees, agents, successors and assigns, from any and all claims and demands arising out of or in connection with the disclosures authorized herein.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Revocation:** I hereby revoke the Authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Written Authorization to Request a CAPS Check

A check of the Colorado Adult Protective Services (APS) data system (CAPS) is required for you (individual) because you are:

- A potential employee/contractor who will provide direct care to at-risk adults, or
- A person who may be appointed as a conservator or guardian of an at-risk adult.

An employer may also request a CAPS check for you if you provide direct care to an at-risk adult and you:

- Were hired/contracted prior to the CAPS check requirement (1/1/2019), or
- Are a volunteer, or
- Will provide services to a CDASS recipient

The CAPS check will alert the employer or court (agency) whether you have or have not been substantiated in an APS case of mistreating an at-risk adult, to include physical abuse, sexual abuse, caretaker neglect, exploitation, and/or harmful act.

More information on the CAPS check requirement can be found in Colorado Revised Statute (26-3.1-111, C.R.S.) and in the Colorado code of Regulations (12 CCR 2518-01).

Written authorization is required from the individual being checked, using this form. Please complete this form in its entirety. Knowingly providing inaccurate information on a CAPS check request is a class 1 misdemeanor pursuant to 18-1.3-501, C.R.S.

### ■ AGENCY INFORMATION (To be completed by the agency.)

Agency Name: Grand River Hospital District

Agency Address: 501 Airport Road Rifle, CO 81650

### ■ INDIVIDUAL'S INFORMATION (To be completed by the individual being checked.)

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Maiden Name/Previous Name(s)/Alias: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN (Last 4 digits): \_\_\_\_\_ DORA License #: \_\_\_\_\_  
*(required for all licensed professionals)*

Provide the Name(s) of Your Previous Employer(s) Over the Past Five (5) Years: \_\_\_\_\_

You must provide at least one (1) personal phone number and one (1) email address.

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

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

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone Extension: \_\_\_\_\_

All individuals are required to provide five (5) years of residential history, regardless of whether in the U.S. or abroad. If you lived outside the US in the past five (5) years, provide the international address(es), including the name of the city and country. If you have lived at your current address less than 5 years, please list your previous addresses for the past 5 years. Use another sheet of paper, if necessary.

Current Address Start Date (DD/MM/YYYY): \_\_\_\_\_

Current Street and Number (No PO boxes): \_\_\_\_\_

Current Address City: \_\_\_\_\_ Current State: \_\_\_\_\_ Current Zip/Postal Code: \_\_\_\_\_

Previous Address Start Date (DD/MM/YYYY): \_\_\_\_\_ Previous Address End Date (DD/MM/YYYY): \_\_\_\_\_

Previous Street and Number (No PO boxes): \_\_\_\_\_

Previous City (City & country for international addresses): \_\_\_\_\_

Previous State (Not required for international addresses): \_\_\_\_\_ Previous Zip Code (Use "00000" for international addresses): \_\_\_\_\_

Previous Address Start Date (DD/MM/YYYY): \_\_\_\_\_ Previous Address End Date (DD/MM/YYYY): \_\_\_\_\_

Previous Street and Number (No PO boxes): \_\_\_\_\_

Previous City (City & country for international addresses): \_\_\_\_\_

Previous State (Not required for international addresses): \_\_\_\_\_ Previous Zip Code (Use "00000" for international addresses): \_\_\_\_\_

Previous Address Start Date (DD/MM/YYYY): \_\_\_\_\_ Previous Address End Date (DD/MM/YYYY): \_\_\_\_\_

Previous Street and Number (No PO boxes): \_\_\_\_\_

Previous City (City & country for international addresses): \_\_\_\_\_

Previous State (Not required for international addresses): \_\_\_\_\_ Previous Zip Code (Use "00000" for international addresses): \_\_\_\_\_

Previous Address Start Date (DD/MM/YYYY): \_\_\_\_\_ Previous Address End Date (DD/MM/YYYY): \_\_\_\_\_

Previous Street and Number (No PO boxes): \_\_\_\_\_

Previous City (City & country for international addresses): \_\_\_\_\_

Previous State (Not required for international addresses): \_\_\_\_\_ Previous Zip Code (Use "00000" for international addresses): \_\_\_\_\_

I, \_\_\_\_\_, by my signature below, authorize the agency referenced above to request a CAPS check to determine if I have a substantiated finding as a perpetrator of mistreatment of an at-risk adult. I acknowledge that a substantiated finding resulting from such a check, unless the finding was expunged through a successful appeal, shall be provided to the person directly involved in the employer's hiring process or the court's hearing process and may be used to inform their decision. I acknowledge notification may occur through CAPS to this agency, for the duration of my employment, volunteer assignment, or authority as an appointed or potential conservator or guardian with them, of any future substantiated findings against me. I understand that willfully providing false information on this form is a misdemeanor 1 penalty, punishable as outlined in §18-1.3-501, C.R.S. I declare under penalty of perjury under Colorado Law that this CAPS Check Request Form, including supporting documents, has been examined by me and is true, correct, and complete.

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

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

CLEAR FORM

PRINT



**COLORADO**  
Adult Protective Services  
CAPS Check Unit