Dear Friend,

Thank you for your interest in Incarnation Children's Center. As you may know, ICC is New York City's only residence for children with HIV/AIDS.

Our mission is to help to provide a safe, nurturing environment where we meet the children's developmental, emotional, social and physical needs. As a volunteer or student, you can help us achieve these goals.

I am enclosing a Volunteer or Intern Application Form and all required paperwork.* Please return to me at your earliest convenience, and feel free to contact me if you have any additional questions.

Sincerely,

Meagan Frederick, MA, LCAT, ATR-BC, CCLS, HTR
Director of Therapeutic Recreation and Volunteer Services

Note: All information obtained through this process is strictly confidential.
Please sign below acknowledging receipt of confidentiality status.

Given to:

____
Signature of volunteer

By: **INCARNATION CHILDREN'S CENTER**

VOLUNTEER REQUIREMENTS & EXPECTATIONS

REQUIREMENTS:

- A commitment of a minimum of 3 hours per week for a minimum of at least 4 months, on designated day and time, unless otherwise stated. Four weeks notice of termination is requested and recommended.
- Only individuals 21 years of age or older will be considered.
- Energy, enthusiasm, and a desire to work with children. Special skills or talents are welcomed. Prior experience with children or a strong background or interest in child development or a related field is preferred.
- Ability to take direction from a supervisor, as well as work independently.
- Completed paperwork, and medical clearance as specified.
- Formal orientation after paperwork is processed.

RESPONSIBILITIES:

- Assist the Recreation Therapist, Intern or Activities Coordinator in group activities, including set-up and clean-up of the activity room.
- Assist with the maintenance of the activity area and materials for patient use.
- Wash hands according to universal safeguards, between each patient contact and before coming to or leaving from each activity area.
- Assist children who are ambulatory or need to be transported in wheelchairs to and from activity area. If you are leaving an area with a child unescorted, you need consent from staff to do so.
- Volunteers are encouraged to make notes of their observations of the children. These notes left for the supervisor may have important information that can be passed on to the health care team. Any suggestions or complaints can be directed to the Director of Therapeutic Recreation and Volunteer Services.

EXPECTATIONS:

- Inform Director of Therapeutic Recreation and Volunteer Services in advance of any absence due to illness or vacation. Two unexcused absences will result in termination from the program. *(Children need to experience consistent relationships and staff need to prepare for groups and events. Your regular attendance is essential to their well-being.)*
- Wear volunteer badge at all times within ICC.
- Sign in all volunteer hours in the volunteer logbook at the front desk. Please make sure to come on time. Continuous lateness will result in termination from the program.
- Report to designated recreation supervisor to receive daily direction and informal supervision.
- Notify Director of Therapeutic Recreation and Volunteer Services if you are no longer able to continue volunteering, or if you must take an extended leave of absence.
- Adhere to all policies and procedures specified by ICC, including safety guidelines, standards of confidentiality, and volunteer limitations.

LIMITATIONS:

- Volunteers may **not** go to the 2nd Floor, unless given permission by the Director of Therapeutic Recreation and Volunteer Services or nursing staff directly.
- Volunteers may **not** give money, buy food or gifts for a child, unless given permission by the Director of Therapeutic Recreation and Volunteer Services. This includes running errands for a child.
- Volunteers may not show up unannounced, or outside of their designated volunteer hours, unless approved beforehand by Director of Therapeutic Recreation and Volunteer Services.
- Volunteers may not take the children outside of ICC, unless they are processed as a Big Brother/Big Sister, or if ICC staff accompanies them.
- Volunteers may not take pictures of the children at any time, for any purpose.
- Volunteers may not read patient charts, at any time, for any reason.
- Volunteers may not discuss illness with a child, or talk about a child's illness or condition either in or out of ICC. Confidentiality rules are taken seriously.

APPLICANT'S AUTHORIZATION and CONFIDENTIALITY STATEMENT
~Please read carefully~

I hereby affirm that the information contained in this application (and accompanying documents) is true and complete to the best of my knowledge. I also agree that any misstatement, falsified information or omission deemed significant by Incarnation Children's Center might disqualify me from further consideration for volunteering.

I understand, furthermore, my volunteering is subject to satisfying the health requirements of Incarnation Children's Center in accordance with the New York City Department of Health and the New York City Department of Social Services.

The Department of Volunteer Services reserves the right to suspend a volunteer for any reason, at any time.

Every patient has the legal right to expect that the confidentiality of his or her medical and psychosocial information will be preserved and respected. A variety of federal and state laws protect this confidentiality. The unlawful use or disclosure of any patient's medical or psychosocial information is subject to civil and criminal liability.

Confidentiality is an ethical responsibility of every volunteer. I understand the right to patient confidentiality. Any information I may learn about a patient will remain strictly confidential. I will never, at any time during or after volunteering, discuss a patient's condition, disclose any information or make copies of any documents relating to a patient's medical psychosocial situation. This confidentiality agreement applies to both inside and outside Incarnation Children's Center.

I will never discus my own medical experience with a patient. I understand that it is considered unethical to give any advice or opinion about a diagnosis or medical treatment without the qualification of medical staff.

In signing this statement, you indicate your understanding of and adherence to the volunteer policies of Incarnation Children's Center.

Applicant's signature ______________________________ Date ____________

____

Print name

VOLUNTEER APPLICATION

Name: ____ Date: ____________________

Address: ____ Phone (H): _______________

____ Phone (C): _______________

Email: ____ Phone (W): ______________

Social security #: _____________________________________

Current Employer: ___________________________________ Business Phone: ______________

Business address: ____________________________________ Job title: ____________________

____

Previous employers:	Dates of employment:	Job title:
____________________________	_________________	_________________________
____________________________	_________________	_________________________

Education:

High School: ____

College: ____

Major: ______________________________________

Minor: ______________________________________

Are you obtaining credit for this placement for school/college?

Yes ______ No ______

If so, please list the course you are obtaining credit for:

____

Is a written evaluation required?:

Yes ______ No _______

How many hours are required for this placement?:

____

List courses in Health, Science, Education, Psychology, Sociology or Development that will be helpful to you in this program:

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

When are you available to volunteer? Please list days and times:

____

____

How many hours per week? The minimum is 3 hours per week. __________________________

How did you learn about Incarnation Children's Center?

____

____

There are many places where you can work with children. Why did you choose to work here?

____

____

____

Please list prior experience you have had working with children:

____

____

____

____

Do you have any physical, medical or psychological condition(s) we should be aware of?

____

____

What were your reactions to illness in the past?

____

____

____

____

What kinds of situations do you think you may see and experience here at Incarnation Children's Center?

____

____

____

____

How do you think you would handle your feelings if you were working with (1) an acutely ill or (2) a terminally ill child?

(1)____

____

(2)____

____

You will be under supervision most of the time during your placement here. How do you feel about this?

____

____

____

What do you hope to gain from this experience?

____

____

____

List any special skills/talents:

____

____

____

Any additional comments or concerns:

____

____

____

In case of emergency, contact:

Name: ____

Phone (H): ____

Phone (W): ____

Signature: ____

Contact Meagan Frederick, MA, LCAT, ATR-BC, CCLS, HTR at 212-928-2590 x27 with any further questions or concerns.

Return completed application and paperwork to above address or fax to 212-928-1500.

Incarnation Children's Center

Volunteer Health Release Document

In order to volunteer at Incarnation Children's Center, state law requires that a physician provide the following information:

Volunteer name: ____

Date of birth: ____

Two PPD Tests administered within 7 - 21 days of each other: (must be read by a heath care provider: MD, NP, PA, RN, LPN and result expressed in mm)	**Date of 1st PPD**: __________ **1st PPD results**: __________ **Date of 2nd PPD**: __________ **2nd PPD results**: __________

Is there any history of exposure to an active TB case? YES* NO

Is there any clinical suspicion of current, active, infectious TB disease? YES* NO

Disease History, Titer or Immunization status for: (specify disease, titer or vaccine with date(s)	Chicken Pox: _______________ Hepatitis B: _______________ Hepatitis C: _______________
Dates of MMR vaccinations: **2 required, or*	1) _________________________ 2) _________________________
Result and date of Titer test:	Measles: ___________________________ Mumps: ___________________________ Rubella: ___________________________

Are there any reasons why this person might be unable to volunteer? YES* NO

Physician's name: ______________________________ Phone number: ____________

Signature: _____________________________________ Date: ____________________

**** is yes, further review of this application will be required by the Medical Director at Incarnation Children's Center.***

Please return to Meagan Frederick, Director of Therapeutic Services & Volunteers, at Incarnation Children's Center, 212-928-2590 x27. Fax 212-928-1500.

Feel free to contact Meagan with any further questions.

For Office Use Only:

MD Approval/Clearance: ____________
Initials

Instructions for Completing the Statewide Central Register Database Check Form

LDSS-3370

- **ALL** information on the form must be easily read so that data entry and results are accurate. Each SCR Database Check submitted should be reviewed for completeness and legibility by the program/agency liaison. If the form is incomplete or illegible, it will be returned to the agency for corrections.

THE PROPER WAY TO COMPLETE THE FORM:

AGENCY INFORMATION

TOP LINE OF FORM:

- The three-digit agency code must be placed in the top left-hand box, followed by the Resource I.D. (RID) in the next box to the right. (Contact the licensing agency if there are any questions about these.)
- Daycare providers must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID number. (Contact your licensing agency/Regional Office if you have any questions).
- Clearance Category letter code (see back of Form LDSS-3370) must be placed in the middle box.
- Phone number (with area code) enables the SCR to contact the agency liaison if this becomes necessary.
- The Request ID Box is for SCR use only.

AGENCY ADDRESS AREA:

- Agency Name: Please use full name, no abbreviations
- Agency Liaison is the contact person at the inquiring agency. (*The SCR response will be addressed to the liaison.) **The liaison cannot be the applicant or a relative of the applicant.**
- Agency Address: Must include street, city

APPLICANT INFORMATION

APPLICANT/HOUSEHOLD MEMBER AREA:

- **ALL** HOUSEHOLD MEMBERS, ADULTS AND CHILDREN, WHETHER RELATED TO THE APPLICANT OR NOT, ARE TO BE LISTED IN THIS AREA OF THE FORM.
- Remember to **write clearly** or **type** all information in order to assist in obtaining an accurate response. Record all names with the last name first, then the first name, and middle name.
- First line: Applicant's name. If there is more than one applicant place the additional name(s) on the lines below the maiden name line.
- Second line: Any maiden names, previous married names, or aliases by which the applicant is or has been known. Use additional lines if there is more than one maiden/married/alias name to be listed.
- Remaining lines: Names of all other household members. (Attach an additional page if needed.)

If there are no other household members, indicate NONE on the line below "Maiden/Alias".

- First column: indicate the relationship to the applicant of each person listed. (Spouse, son, daughter, mother, father, friend, etc.)
- Sex M/F column: fill in either M (Male) or F (Female) for every person listed.
- Date of Birth column: fill in complete date of birth (mm/dd/yy) for everyone listed on the form.

ADDRESS AREA:

The information required varies depending on the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for categories), provide addresses for the applicant and any household member who is 18 and older. We need this information for the last 28 years. Attach supplemental pages if necessary, but **do not use** another LDSS-3370 form to list this additional information. Be sure to associate address histories with particular individuals (i.e., indicate which addresses are for which household members).
- For all other categories, only the applicant's address history is required – for the last 28 years.
- Complete addresses are required. Include street name and city/town/village. Also include street number and apartment number. **Post Office Box numbers are not acceptable.** If the applicant has lived abroad, indicate country and dates of residence. If the applicant has spent time in the military, list base names and locations along with dates. **Be sure that there are no periods of time unaccounted for.**
- The top line is for the current address. The previous address should be listed on the second line downward, and so on to the back of the form for the last 28 years. Staple the attached supplemental page to the form if more space is needed, but do not use another copy of the LDSS-3370 for this additional information.

SIGNATURE AREA:

Signatures required depend upon the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for category), signatures are needed from the applicant and any household member who is 18 or older.
- For all other categories, only the applicant's signature is required.
- All signatures must correspond to the names recorded in the Applicant/Household Member Area-for example; Mary Smith should not sign Mary Ann Smith. Victoria Smith should not sign Vicki.
- Applicants must sign in the boxes marked "Applicant's Signature", household members over 18 who are not applicants must sign in the boxes at the extreme bottom of the page marked "Signature".
- All signatures must be dated (mm/dd/yy). The SCR **will not accept** a form with a signature date more than 6 months old.

If you have questions regarding proper completion of this form, **please call the SCR at 518-474-5297.**

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

STATEWIDE CENTRAL REGISTER
P.O. BOX 4480
ALBANY, N.Y. 12204-0480

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

Please access the (OCFS-4627) **Request for Forms and Publications**, from the Intranet: http://ocfs.state.nyenet/admin/forms/SCR/ Internet: http://www.ocfs.state.ny.us/main/forms/cps/ and mail the completed OCFS-4627 Request for Forms and Publications, to: **THE OFFICE OF CHILDREN AND FAMILY SERVICES, RESOURCE DISTRIBUTION CENTER, 11 FOURTH AVE, RENSSELAER, NY 12144.**

LDSS-3370 (Rev. 04/2009) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER **(Area Code):**
INB	875		Z	(646) 633 - 4408

PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME: TERENCE CARDINAL COOKE HEALTH CARE CENTER

AGENCY LIAISON: KENNETH DRAYTON

STREET ADDRESS 1249 FIFTH AVENUE

CITY: NEW YORK **STATE:** NY **ZIP CODE:** 10029

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" *List RELATIONSHIP in the fields below*

(see reverse side for instructions) Attach additional page if necessary.

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA *PLEASE TYPE OR PRINT CLEARLY

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH		
APPLICANT						
MAIDEN/ALIAS						

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE	APPLICANT'S SIGNATURE	DATE

EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE	SIGNATURE	DATE