Pope's Kids Place

Board Member Information Form

Name: ______________________________________ **Date:** ____________

Home Address: _____________________________

City: ________________________ **State:**________ **Zip Code:** ______

Phone #: ____________ **Cell Phone #:** ___________

E-Mail #: ____________________________

Business/Occupation

Employer: ____

Title: ____

Business Address: ____________________________

City: _______________________ **State:** ________ **Zip Code:** _______

Phone #: _____________ **Fax:** ____________**E-Mail:**___________________

I wish Pope's Kids Place information/meeting notices mailed to my home address _____ or business address _______

1) What talents/interests do you bring to the Board?

____

____

____

____

2) Why do you wish to be a member of the Board of Pope's Kids Place?

____

____

____

____

Please attach a brief résumé.

Background Authorization

Read the attached instructions before completing this form.

SECTION 1. ENTITY INFORMATION (COMPLETED BY DSHS STAFF, PROVIDER, APPLICANT, LICENSEE, AND/OR CONTRACTOR)

1A. GIVE NAME OF PERSON OR ENTITY REQUESTING THIS BACKGROUND CHECK	1B. **SEE INSTRUCTIONS:** GIVE ENTIRE ADDRESS OF PERSON OR ENTITY REQUESTING THE CHECK	1C. **REQUIRED BY CHILDREN'S ADMINISTRATION ONLY:** GIVE NAME OF FACILITY/FOSTER HOME
Pope's Kids Place	**230 Washington Way Centralia WA98531**	**Pope's Kids Place**

2. NAME AND SIGNATURE OF PERSON REQUESTING THE BACKGROUND CHECK

PRINTED NAME: **Administration** SIGNATURE:

3. A. **REQUIRED ONLY FOR ECONOMIC SERVICES ADMINISTRATION:**

☐ WorkFirst contract ☐ Protective Payee ☐ In-home relative ☐ In loco parentis

B. **REQUIRED ONLY FOR CHILDREN'S ADMINISTRATION:**

☐ State foster care ☐ Private agency foster care ☐ Adoption ☐ DCFS relative placement ☐ Contracts

☐ Subject of (or related to) CPS investigation ☐ Residential facility or child placing agency employee

C. **REQUIRED ONLY FOR ADULT PROTECTIVE SERVICES:**

☐ Subject involved in (or related to) APS investigation per RCW 74.34

D. **REQUIRED ONLY FOR DSHS STATE EMPLOYMENT:**

DSHS POSITION NUMBER ____________ **(WRITE NONE IF NONE)** DSHS JOB CLASSIFICATION: ____________ PERSONNEL IDENTIFICATION NUMBER: ____________

☐ Permanent appointment ☐ Non-permanent appointment ☐ Work study ☐ Volunteer ☐ Student internship ☐ Layoff ☐ On-Call

4. **SEE INSTRUCTIONS:** BCCU ACCOUNT NUMBER	5A. **SEE INSTRUCTIONS:** DSHS ID NUMBER OR NAME	5B. **FOR WEB SERVICE FINGERPRINT CHECK:** BCCU INQUIRY ID NUMBER

SECTION 2. THIS SECTION IS FOR APPLICANT INFORMATION ONLY (THE PERSON TO BE CHECKED IS THE APPLICANT)

6. **SEE INSTRUCTIONS:** SOCIAL SECURITY NUMBER	7. PRINT YOUR DATE OF BIRTH (MM/DD/YYYY)

8A. SEE EXAMPLE IN INSTRUCTIONS: PRINT YOUR LAST NAME AS IT IS NOW **(WRITE NONE IF NONE)**	SEE EXAMPLE IN INSTRUCTIONS: PRINT YOUR FIRST NAME AS IT IS NOW **(WRITE NONE IF NONE)**	SEE EXAMPLE IN INSTRUCTIONS: PRINT YOUR MIDDLE NAME AS IT IS NOW **(WRITE NONE IF NONE)**
8B. PRINT YOUR LAST NAME AT BIRTH **(WRITE NONE IF NONE)**	PRINT YOUR FIRST NAME AT BIRTH **(WRITE NONE IF NONE)**	PRINT YOUR MIDDLE NAME AT BIRTH **(WRITE NONE IF NONE)**

9. PRINT OTHER LAST NAMES YOU HAVE USED AND LAST NAMES YOU HAVE BEEN KNOWN BY **(WRITE NONE IF NONE)**

10. PRINT YOUR NICKNAMES AND ALL OTHER FIRST NAMES YOU HAVE USED AND HAVE BEEN KNOWN BY **(WRITE NONE IF NONE)**

11A. Have you been convicted of any crime? If yes, fill in the blanks below. Add a page if you need more room. ☐ Yes ☐ No

Felony and gross misdemeanor crimes: ____________________ Degree:______ State:______ Conviction date: ______________

11B. Do you have charges (pending) against you for any crime?
If yes, fill in the blanks below. Add a page if you need more room. ☐ Yes ☐ No

Felony and gross misdemeanor crimes: ____________________ Degree:______ State:______

12. Have you ever received a notice from a court or state agency stating that you have sexually abused, physically abused, neglected, abandoned, or exploited a child, juvenile, or adult? ☐ Yes ☐ No

13. Has a court or state agency ever denied you a contract or license; terminated, revoked or suspended your contract or license; or have you ever given up your contract or license because a court or agency was taking action against you? ☐ Yes ☐ No

14. Has a court ever written an order of protection or a restraining order lasting more than 30 days against you for abuse, neglect, financial exploitation, domestic violence, or abandonment of a vulnerable adult, juvenile, or child? ☐ Yes ☐ No

15. PRINT YOUR DRIVER'S LICENSE OR STATE IDENTIFICATION NUMBER **(WRITE NONE IF NONE)**	PRINT THE NAME OF THE STATE ON YOUR LICENSE OR ID

16. How many years have you lived in Washington State without living in another state? ______ Years / ______ Months

17. A. PRINT THE STREET ADDRESS WHERE YOU LIVE NOW | CITY | STATE | ZIP CODE | COUNTY

B. **SEE INSTRUCTIONS:** PRINT THE STREET ADDRESS WHERE YOU LIVED BEFORE YOUR CURRENT ADDRESS | CITY | STATE | ZIP CODE | COUNTY

C. **SEE INSTRUCTIONS:** GIVE THE DAYTIME AREA CODE AND TELEPHONE NUMBER WHERE YOU CAN BE REACHED

18. I am the person named above. If I do not tell the whole truth on this form, I understand I can be charged with perjury and I may not be allowed to work with vulnerable adults, juveniles or children. My signature in box number 19 means:

- I give DSHS permission to check my background with any governmental entity and law enforcement agency.
- If a founded finding is identified, I give DSHS permission to give only my name and that a founded finding was identified to any persons or entities in Section 1.
- I give DSHS permission to give all my other background information to the persons or entities named in Section 1.
- This permission is good for 90 days from the date signed. I can change my mind about this permission in writing at any time.

19. **REQUIRED:** YOUR SIGNATURE. YOUR PARENT OR GUARDIAN'S SIGNATURE IF YOU ARE UNDER 18.	20. **REQUIRED:** TODAY'S DATE (MM/DD/YYYY)

FOR USE BY CHILDREN'S ADMINISTRATION STAFF ONLY

CAMIS files checked by on date ☐ No information found ☐ Information available

INSTRUCTION SHEET FOR FILLING OUT THE BACKGROUND AUTHORIZATION FORM

You MUST fill in ALL boxes on this form as instructed. READ the instructions for each Section and each box.

You MUST put an answer in the box. You can put NO, NOT APPLICABLE (N/A), OR NONE– except BOX number 3 –

DO NOT answer any question by putting UNKNOWN or a QUESTION MARK in the box. if you do, the form will be sent back.

Print clearly with black ink. Read each question carefully.

Check with your DSHS program to find out if you must fill in boxes marked "SEE INSTRUCTIONS"
_____ (This box allows your program to insert their requirements.)

You MUST put an answer in every box and return this form to: _____ (This box allows the person, program, or entity to insert the address or fax number where the form is to be returned.)

Most background authorization forms are sent back to the requester for the following reasons:

- Wrong form.
- Blank boxes.
- Bad handwriting.
- Missing or wrong BCCU account number.
- Person under 18 signs the form without a parent or guardian signature.
- Date signed is older than three (3) months from the date BCCU received the form.

<u>SECTION 1</u>: **This section must be completed by the person or entity requesting this background check.** An entity may be a facility, business, organization, or agency such as a Nursing Home, a Rehabilitation Center, or a DSHS Office.

If you are applying to be a licensed Adult Family Home, Boarding Home, or Nursing Home, **SKIP SECTION 1**. GO directly to SECTION 2.

1. **A.** **You MUST** put the name of the entity or person asking for the background check. An entity may be a DSHS office. A person may be someone applying for a license or a service provider contract. Ask your DSHS program to tell you what person's name or the name of the entity that is required for this box.
   _____ (This box allows your program to insert requirements.)

   B. Ask your DSHS program if you are required to fill in the address of the entity or person asking for the background check. Put N/A in this box if NOT required by your program.
   _____ (This box allows your program to insert requirements.)

   C. **This box is** ONLY for Children's Administration. Children's Administration: Fill in the name of the facility or foster home.

2. **You MUST** print and sign your name if you are the person asking for the background check. <u>The person who is being checked signs in box 19.</u>

3. DO NOT WRITE ANYTHING IN THESE BOXES UNLESS you are an employee of Children's Administration, Economic Services Administration, Adult Protective Services or a DSHS hiring authority.

   D. Personnel ID Number is the permanent number assigned to every staff person by the Department of Personnel (DOP).

4. **You MUST** put your BCCU account number in this box. You can find your BCCU account number at http://www1.dshs.wa.gov/msa/bccu/index.htm. If this form is part of your application for **license** as an Adult Family Home, Boarding Home or Nursing Home, you **DO NOT** need to give the BCCU account number. You MUST do the following:
   - Adult Family home – Put an **A** in front of your license number.
   - Boarding home– Put a **B** in front of your license number.
   - Nursing home– Put an **N** in front of your license number.

5. **A.** You MUST ask your DSHS program if they require you to have an ID number or a name in this box. Put N/A in this box if NOT required by your program.
   _____ (This box allows your program to insert requirements.)

   B. DSHS ONLY – Put N/A if you are NOT a DSHS staff person using Web Service for fingerprint background checks. This ID number is for DSHS staff to track background checks. Any program may use this box for their own tracking purposes.

SECTION 2: You MUST fill out this section if you are the person we are checking. Note: A DSHS employee asking for a background check for an Adult Protective Services (APS) or Child Protective Services (CPS) investigation MUST fill out this section as best he or she can.

6. You MAY put your social security number (SSN) in this box. Your SSN is not required to conduct a background check.
   ______ (This box allows your program to insert requirements.)

7. **You MUST** fill in your date of birth.

8A. **You MUST** put your whole name. If you do not have a name to put in this box, **you MUST** put **NONE**.
SEE EXAMPLE BELOW.

EXAMPLE:

PRINT YOUR LAST NAME AS IT IS NOW	PRINT YOUR FIRST NAME AS IT IS NOW	PRINT YOUR MIDDLE NAME AS IT IS NOW
NONE	*"Prince"*	*NONE*

B. **You MUST** put your whole birth name. **You MUST** put **SAME** if any of your names are the same as the names you put in box 8A.

9. **You MUST** put last names you have used or have been known by. **You MUST** put **NONE** if you have NOT used or been known by any other last names.

10. **You MUST** put any nicknames you have used. **You MUST** put **NONE** if you have NOT used any nicknames.

11. **You MUST** answer **YES** or **NO**. If your answer is **YES** to A. or B., **you MUST** fill in your conviction and pending charge information.

12. **You MUST** answer **YES** or **NO**.

13. **You MUST** answer **YES** or **NO**.

14. **You MUST** answer **YES** or **NO**. Put **YES** if the protection order lasted longer than 30 days and it was for the protection of a vulnerable adult, juvenile or child.

15. **You MUST** put your driver's license or state identification number in the box. **You MUST** put the name of the state in the box. **You MUST** put **NONE** if you do not have a driver's license or state identification number.

16. **You MUST** put the number of years and months you have lived in Washington State without living in another state or country. If you have moved out of Washington to another state or country, **you MUST** start counting the years and months from the date you moved back to Washington State. **Note**: **You MUST** ask your program if you have to get a fingerprint check.

17. **A. You MUST** fill in the address where you live now.
    B. Your program may require you give your old address. Ask your DSHS program. Put N/A in this box if NOT required by your program.
    ______ (This box allows your program to insert requirements.)
    C. Ask your program if your telephone number is required. You **MUST** put **NONE** if you do not have a telephone number.
    ______ (This box allows your program to insert requirements.)

18. **You MUST** read the statement in this box. Your signature under number 19 means you have read and agree to the statements in number 18. This background authorization form does NOT take the place of a public disclosure request for records about a founded finding. Founded finding means a state agency has taken a legal action against someone after an investigation and notice of a decision about abuse, sexual abuse, neglect, abandonment or exploitation or financial exploitation of a vulnerable adult, juvenile or child.

19. **You MUST** sign your name here. If you are NOT 18 years old, **your parent or guardian MUST** sign here.

20. **You MUST** fill in the date you signed this form.

ATTENTION APPLICANTS:
If you want to know the status of your background check form or need information about the BCCU background check process, contact BCCU at: bccuinquiry@dshs.wa.gov

ATTENTION ENTITIES AND DSHS STAFF: You MUST report errors in your address, telephone number or fax number to BCCU at **bccuinquiry@dshs.wa.gov** or (360) 902-0299. Put your BCCU account number in your email.

Pope's Kids Place

Board Member Agreement

I understand that as a member of the Board of Directors of Pope's Kids Place I have a legal and moral responsibility to ensure that the organization does the best work possible in pursuit of its goals and in keeping with its mission. I believe in the purpose and mission of Pope's Kids Place, and I will act responsibly and prudently as its steward.

As a part of the responsibilities as a board member:

1. I will interpret the organization's work and values to the community, represent the organization, and act as a spokesperson.
2. I will attend at least 75% of board meetings, committee meetings, and special events.
3. I will make a personal financial contribution to Pope's Kids Place at a level meaningful to me.
4. I will actively participate in one or more fundraising activities per year of my membership on the board.
5. I will act in the best interests of the organization, and excuse myself from discussions and votes where I have a conflict of interest.
6. I will stay informed about what's going on in the organization. I will ask questions and request information. I will participate in and take responsibility for making decisions on issues, policies, and other board matters.
7. I will work in good faith with staff members and other board members as partners towards achievement of the goals and vision of Pope's Kids Place.
8. If I don't fulfill these commitments to the organization, I will expect the board president to call me and discuss my responsibilities with me.

In turn, Pope's Kids Place will be responsible to me in the following ways:

1. I will be sent, without request, financial reports at least quarterly and an update of organizational activities that allow me to meet the "prudent" person section of the law.
2. Opportunities will be offered to me to discuss with the executive director and the board president the organization's programs, goals, activities, and status. I am entitled to request such opportunities as I see fit.
3. The organization will help me perform my duties by keeping me informed about issues in the industry and field in which Pope's Kids Place works and by offering me opportunities for professional development as a board member.
4. Board members and staff will respond in a straightforward fashion to questions I have that I feel are necessary to carry out my fiscal, legal, and moral responsibilities.
5. If the organization does not fulfill its commitments to me, I can call on the board president and the executive director to discuss these responsibilities.

______________________________ ______________
Signature of Member of the Board of Directors Date

______________________________ ______________
Signature of President of the Board of Directors Date

Pope's Kids Place

230 Washington Way
Centralia WA 98531
www.popeskidsplace.org
Administration: 360 736-9178
Fax: 360 736-9183

SUBJECT: Conflict of Interest for Board members

POLICY: Board members are to disclose in writing to the entire board if they, or any member of their immediate families, or any organization with which they are affiliated, presently transact business with Pope's Kids Place or might reasonably be expected to do so in the future.

PURPOSE: To prevent possible favoritism when making decisions on behalf of Pope's Kids Place.

PROCEDURE:

1. An affiliation with an organization will be considered to exist when a board member or a member of his or her immediate family is an officer, director, trustee, partner, employee or agent of the organization; or owns five percent of the voting stock or controlling interest in the organization; or has any other substantial interest or dealings with the organization.
2. Board Members with such relationships will not be eligible to vote on matters directly pertaining to the business to be transacted with the identified person or organization or on issues that may result in any benefit inuring to the benefit of the identified person or organization. Minutes of appropriate meetings are to reflect that such disclosure was made, that such board member abstained from voting, and that such board member was not counted for the purpose of determining a quorum.
3. The foregoing requirements, however, are not to be construed to prevent a particular board member from briefly stating his/her position on the matter, nor from answering pertinent questions of other directors by reason of the fact that personal knowledge on the matter may be of assistance to the other board members in reaching their decision.
4. Board members maintaining no such relationships will attest to that fact in writing and agree to notify the board should their status change.

Policy effective date: 1/18/2012 Revision date(s):

Pope's Kids Place
230 Washington Way
Centralia WA 98531
www.popeskidsplace.org
Administration: 360 736-9178
Fax: 360 736-9183

Conflict of Interest Statement

I have read the Conflict of Interest Policy and agree to its terms.

Name: ______________________________

Signature: ______________________ Date: __________

I hereby state that to the best of my knowledge I maintain **no relationship** with a person or organization as defined in the Conflict of Interest Policy that is currently transacting business or expected to transact business with Pope's Kids Place.

Name: ______________________________

Signature: ______________________ Date: __________

I hereby state that **I do have a relationship** with persons or organizations, as defined in the Policy and listed below, which might constitute, or lead to, a conflict of interest.

Name: ______________________________

Signature: ______________________ Date: __________

Entity	Relationship
Entity	Relationship
Entity	Relationship
Entity	Relationship

Confidentiality Statement

All patient Protected Health Information (PHI – which includes patient medical and financial information), employee/volunteer records, financial and operating data, and any other information of a private or sensitive nature are considered confidential. Confidential information should not be read or discussed by any Board Member unless pertaining to his or her specific duties.

Examples of inappropriate disclosures include:

- Board Member discussing or revealing PHI or other confidential information to friends or family members.
- Board Member discussing or revealing PHI or other confidential information to other employees/volunteers without a legitimate need to know.
- The disclosure of a patient's presence in any facility of Pope's Kids Place, without the patient's consent, to an unauthorized party without a legitimate need to know, and that may indicate the nature of the illness and jeopardize confidentiality.

The unauthorized disclosure of PHI or other confidential information by Board Members can subject each individual and the organization to civil and criminal liability. Disclosure of PHI or other confidential to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration, or sabotage of such information, is grounds for immediate disciplinary action up to and including termination.

Confidentiality Agreement

I hereby acknowledge, by my signature below, that I understand that the PHI, other confidential records, and data to which I have knowledge and access in the course of my duties with Pope's Kids Place is to be kept confidential, and this confidentiality is a condition of my association with Pope's Kids Place. This information shall not be disclosed to anyone under any circumstances, except to the extent necessary to fulfill my duties. I understand that my duty to maintain confidentiality continues even after I am no longer associated with Pope's Kids Place.

I am familiar with the guidelines in place at Pope's Kids Place pertaining to the use and disclosure of patient PHI or other confidential information. Approval should first be obtained before any disclosure of PHI or other confidential information not addressed in the guidelines and policies and procedures of Pope's Kids Place is made. I also understand that the unauthorized disclosure of patient PHI and other confidential or proprietary information of Pope's Kids Place is grounds for disciplinary action, up to and including immediate dismissal.

Date ______________

Signature of Board Member __________________________

Print Board Member name ____________________________________

Signature of Board President __________________________

HIPAA Training for Pope's Kids Place

Board Members not having regular contact with clients or patients

HIPAA Health Insurance Portability and Accountability Act

Federal government's attempt to safeguard the confidentiality of Protected Health Information (PHI).

PHI Includes name, address, phone and health care symptoms as well as health condition, disease, lab results, and mental health. Also includes payment or insurance information.

- Oral
- Written
- Electronic – Fax, e-mail

What is Pope's Kids Place doing about Privacy?

- Notice of Privacy Practices to all patients
- Policies and Procedures to safeguard privacy
- Statements of Confidentiality

Who does this apply to?

- EVERYONE who may gather information, look at it, or disclose it

We Must:

- Protect information: without patient permission, NEVER TELL ANYONE (family, friend, neighbor) WHO WAS A PATIENT/CLIENT AT POPE'S KIDS PLACE

Pope's Kids Place Privacy Officers

- Department heads under supervision of Executive Director

Without patient permission, DO NOT TELL FAMILY MEMBERS, FRIENDS, NEIGHBORS WHO WAS IN OUR FACILITY – no matter what department they were in.

HIPAA PRIVACY TRAINING CHECKLIST

For Board Members not having regular contact with clients or patients

For each area place a check in the box as each item is completed:

- ☐ Read or participate in HIPAA Training for Pope's Kids Place
- ☐ Be aware of "Notice of Privacy Practices"
- ☐ Be aware of "Policy: Complaint and Grievance Regarding PHI"
- ☐ Be aware of "Policy: Minimum Necessary Requirements for the Use and Disclosure of PHI"
- ☐ Sign confidentiality agreement

Name of Board Member ____________________________

Signature of Board Member ________________________________

Date Completed ____________________