Mental Health Association

in Orange County, Inc.

NADIA ALLEN, EXECUTIVE DIRECTOR

Volunteer/Intern Application

Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ E-mail: _____

Telephone: _____ Cell: _____

Mental Health Association in Orange County, Inc. is committed to a policy of equal opportunity and will not discriminate against an applicant based on their age, sex, pregnancy, sexual orientation, race, color, creed, religion, national origin or ancestry, citizenship, marital status, disability, victim of domestic violence, military or veteran status or any other category protected under federal, state or local law, regulation or ordinance.

Are you now, or have you ever been registered in a Child Abuse Registry Clearinghouse for New York or any other state? *The names of applicants who will have the potential for regular and substantial contact with children will be submitted to the NYS Central Register for Child Abuse and Maltreatment to determine if applicant is the subject of an indicated report of child abuse or maltreatment.*

☐ **Yes** ☐ **No**

Have you ever been convicted of a crime? *This question does not apply to convictions which have been expunged, sealed, pardoned or otherwise exonerated or eradicated, or relate to youthful offender conviction or violation. (A conviction record will not necessarily be a bar to volunteering/interning. A conviction which is substantially related to the functions or qualifications of the positions of which you are applying may be taken into consideration). If "Yes," please describe fully the criminal conviction(s) listing the nature and date of the offense(s) and your rehabilitation since the conviction(s).*

☐ **Yes** ☐ **No**

_____

_____

Do you have any pending criminal charges in any jurisdiction: ☐ **Yes** ☐ **No**
If yes, please provide the date, jurisdiction and status: _____

_____

What times and days are you available? Some of our programs operate 24 hours a day, 7 days a week.

☐ **Monday-Friday** ☐ **Saturday- Sunday**

The best times for me are: _____

Do you have any prior or current experience in direct care work relevant to the program(s) you are interested in?

☐ **Yes** ☐ **No**

If yes, please explain: _____

_____

Please describe any specialized education or training, if any: _____

_____

What foreign languages do you speak?_____

Read? _____ **Write?** _____

Please describe any current/relevant activities, interests, hobbies or volunteer experiences:

_____

Please state briefly what experiences you are looking to gain by volunteering/interning with our agency?

_____

What programs are you interested in volunteering/interning for?

☐ **Administration** ☐ **Compeer** ☐ **Helpline** ☐ **Vet2Vet** ☐ **Hudson House**

☐ **Home-to-Stay** ☐ **CAPIS** ☐ **Invisible Children's Project** ☐ **Other** _____

For Interns:

What school are you currently attending? _____ **Year of graduation:**_____

How many hours does your internship require?_____

For detailed information on our programs, please visit our web site at: www.mhaorangeny.com

73 James P. Kelly Way * Middletown, NEW YORK 10940 * (845) 342-2400 FAX (845) 343-9665
www.mhaorangeny.com *e-mail: mha@mhaorangeny.com
PATRICIA QUINN, PRESIDENT * A UNITED WAY AGENCY

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MHA Volunteer/Intern Reference Check

Name: _____

Please provide **3** references. You may use personal or professional references.

1. Name: _____

Address: _____

City: _____ State: _____

Telephone: _____ Email: _____

In what capacity do you know this person? _____

_____

2. Name: _____

Address: _____

City: _____ State: _____

Telephone: _____ Email: _____

In what capacity do you know this person? _____

_____

3. Name: _____

Address: _____

City: _____ State: _____

Telephone: _____ Email: _____

In what capacity do you know this person? _____

_____

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Pledge of Confidentiality

Mental Health Association in Orange County, Inc. operates under the Federal Law, HIPAA. HIPAA stands for the Health Insurance Portability and Accountability Act. This law prohibits any person(s) from discussing service participants outside the confides of this agency. Therefore you may **NOT** disclose any personal information about any Mental Health Associations' clients.

I understand that:

- □ All information regarding program participants will be kept discreetly and confidentially within MHA.
- □ No information is to be discussed, or in any way communicated outside this agency without client permission.
- □ Confidential information is any identifying information on an individual. This is Protected Health Information (PHI) and is not to be disclosed. Name, phone number, social security **#,** address, etc. cannot be disclosed.
- □ I agree to attend an agency sponsored Orientation Training which will include HIPAA training prior to starting with MHA.
- □ Any question's regarding a client of MHA should be directed to Angela Jo Henze, MHA's HIPAA privacy officer @ (845)342-2400 x269.
- □ Any information gathered during your time at MHA must not be shared. In addition, all material provided by MHA must be returned if your volunteer experience should end.

Signed: _____

Date: _____