JOA
JUVENILE OFFENDER ADVOCATE

VOLUNTEER/INTERN APPLICATION

Contact Information

Name: _____ E-mail: _____

Address: _____

Cell Phone: _____

Interests

How did you first learn of JOA?

What interests you about JOA? Why would you like to volunteer/intern with this nonprofit organization?

Describe the type of volunteer/intern work you are looking to do at JOA. Please be specific.

Have you volunteered or interned for organizations dealing with youth before?

Availability

Are you currently employed? Yes ☐ No ☐

Are you currently in school? Yes ☐ No ☐ If yes, which school? _____

Are you currently retired? Yes ☐ No ☐

Will you be receiving academic or other credit for volunteering/interning? Yes ☐ No ☐

Please indicate what months and year(s) you will be available.

Jan ☐ Feb ☐ March ☐ April ☐ May ☐ June ☐

July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec ☐

Year(s) _____

Please indicate what days you will be available.

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

How many hours per week do you anticipate volunteering/interning? _____

Thank you for your interest and good luck!

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VOLUNTEER BACKGROUND CONSENT FORM

_____
LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH_____SOCIAL SECURITY NO_____

DRIVERS LICENSE #_____STATE WHERE ISSUED_____

STREET ADDRESS_____

CITY_____STATE_____ZIP CODE_____

TELEPHONE NUMBER_____

EMAIL ADDRESS_____

Gender: _____ Male _____ Female

Race: _____ African American
_____ Asian/Pacific Islander
_____ Caucasian
_____ Hispanic
_____ Other

I authorize Juvenile Offender Advocate Inc. (JOA) to conduct a complete criminal history check as a basis of my placement as an employee or volunteer with the organization. I understand that I am to report any changes in my criminal history to Juvenile Offender Advocate Inc. (JOA).

_____ _____
SIGN DATE

JUVENILE OFFENDER ADVOCATE

HIPAA RELEASE FORM

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II

Health Information I would like to give the above healthcare organization permission to: Tick as appropriate Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions. Or Disclose my complete health record except for the following information Mental health records Communicable diseases including, but not limited to, HIV and AIDS Alcohol/drug abuse treatment records Genetic information

Other (Specify) _____

_____

_____

_____

Form of Disclosure: Electronic copy or access via a web-based portal Hard copy

Section III

Reason for Disclosure Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write ‘at my request’.

_____

_____

_____

_____

_____

Section IV

Who Can Receive My Health Information I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s) Name:

_____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V

Duration of Authorization this authorization to share my health information is valid: Tick as appropriate a) from _____ to _____

Or b) All past, present, and future periods

Or c) The date of the signature in section VI until the following event:
_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that: In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data. I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____
_____
_____
_____

JUVENILE OFFENDER ADVOCATE

BACKGROUND CHECK POLICY

Approved 8/01/2020

Juvenile Offender Advocate Inc. (JOA) is committed to selecting and retaining the best staff and volunteers to serve its youth. As part of the initial selection process and on an on-going basis, JOA will conduct background checks in accordance with the following policy:

JOA will conduct criminal background checks of all employees and volunteers, including minors, who have direct, repetitive contact with juvenile offenders. Name-based or fingerprint based record searches may be used in any combination but shall, at a minimum, (a) verify the person's identity and legal aliases, (b) provide a national Sex Offender Registry search, and (c) provide a national criminal record search. Such checks shall be conducted prior to employment and at regular intervals not to exceed twelve (12) months.

All background check findings shall be considered when making employment or volunteer decisions. It is the policy of JOA that an employee or volunteer will be automatically **ineligible** for employment or volunteer service, if such individual:

(a) refuses to consent to a criminal background check,
(b) makes a false statement in connection with such criminal background check,
(c) is registered, or is required to be registered on a State or National sex offender registry,
(d) has been convicted of a felony consisting of:
    1. murder,
    2. child abuse,
    3. a crime against children, including child pornography,
    4. spousal abuse,
    5. a crime involving rape or sexual assault,
    6. arson or
    7. physical assault, battery,
(e) has been convicted of a drug related offense committed within the last five years.