ABILITIES FIRST
ENRICHING THE LIVES OF PEOPLE WITH DISABILITIES

Abilities First, Inc.
70 Overocker Road
Poughkeepsie, New York 12603
Phone: 845-485-9803 Fax: 845-473-1270

VOLUNTEER/INTERN APPLICATION

DATE	**NAME:** Last, First, Middle	**TELEPHONE #**
ADDRESS		

YOUR INTERESTS:	**Children's Programs _____**	**Adult Programs _____**
Service Coordination _____	**Residential Programs _____**	**OTHER:**

YOUR AVAILABILITY:						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

AFFILIATION (if applicable)
NAME OF SCHOOL OR AGENCY
ADDRESS & PHONE NUMBER
FIELD WORK SUPERVISOR
DEGREE MAJOR

PROGRAM PLACEMENT REQUESTED:
Why are you interested in a volunteer/intern appointment at ABILITIES FIRST, Inc.?

AN AFFIRMATIVE ACTION/EQUAL OPPORTUNITY EMPLOYER M/F/V/H
CRIMINAL BACKGROUND CHECK REQUIRED BY NEW YORK STATE OPWDD/JUSTICE CENTER

REQUIRED MEDICAL INFORMATION: Please attach a copy of TB Manitoux testing results administered within the last twelve months. If none available, one will be provided upon acceptance into the program. A two step PPD may be required, as OPWDD requirements specify.
What hobbies, skills, special interests, training, and/or related experience would you like to utilize as an ABILITIES FIRST, INC. volunteer/intern?
Community Affiliations/Volunteer History (clubs, social groups, other organizations)

CHARACTER REFERENCES

Please list the names and addresses of three (3) people who would be willing to respond to a reference request for you.

Is there additional information you would care to share with us which would pertain to your application for a volunteer assignment at ABILITIES FIRST, INC.

STATEMENT OF APPLICATION

The above statements are true and all information and reference given on this application may be investigated without liability of ABILITIES FIRST, INC. If accepted to participate in the Volunteer Program I agree to abide by the policies of ABILITIES FIRST, INC. I understand that any of the statements in this application are found to be untrue, or I fail to comply with all stated requirements, I may be subject to immediate dismissal from the agency's Volunteer Program.

Signature:	**Date:**

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HUMAN RESOURCES INFORMATION

To be completed by Program Supervisor

Start Date	Orientation Schedule	Program Director Signature & Date

Affirmative Action Policy

TO: All Staff, Job Applicants, Interested Parties
FROM: Human Resources Dept.
RE: Equal Employment Opportunity/Affirmative Action Policy

Abilities First, Inc. wishes to reaffirm that it will comply with federal, state and local anti-discrimination laws and rules as they relate to employment with this Agency. Specifically, we will not discriminate on the basis of race, color, creed, disability, religion, age, marital or health status (to include those with known or suspected HIV (AIDS status), sex, sexual orientation, gender identity, disability, the presence of a non-job-related medical condition or disability or any other basis of discrimination prohibited by law. We will not tolerate sexual harassment of employees.

With the exception of those positions for which there exists a **bona fide occupational qualification** permitting use of an otherwise prohibited factor, this agency will not take any of those factors into consideration with regard to recruitment, hiring, promotion, transfer, disciplinary procedures, separations and other terms and conditions of employment. Additionally, the Agency will take affirmative action to recruit, hire and advance through promotion minority persons, the disabled and veterans.

This endeavor, and its goal of achieving and maintaining equal employment opportunity for all persons, is of the highest priority for this organization, and the community, and has the full and positive support of the management of this organization.

AFFIRMATIVE ACTION SURVEY

Government agencies require periodic reports on the sex, ethnicity, disability and veteran status of applicants. This data is for analysis and affirmative action only. Submission of information is voluntary.

Check One:	Male ☐	Female ☐			
Check one of the following Race/Ethnic Groups:	White ☐	Black ☐	Hispanic ☐	American Indian/ Alaskan Native ☐	Asian/Pacific Islander ☐
Check if any of the following are applicable:	Vietnam Era Veteran ☐	Disabled Veteran ☐	Disabled Individual ☐		

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RELEASE AUTHORIZATION

I hereby authorize past employers, professional acquaintances, and friends to release unto ABILITIES FIRST, INC. or its agents thereof, any information related to my employment history with said company, including but not limited to, dates of employment, attendance, performance, conduct/discipline, capabilities and other qualities related to my qualifications for employment. I further release the said company(s) and/or agents from any claims that may arise for providing such information.

Signature_____ Date_____

PRE-EMPLOYMENT
CONTAGIOUS DISEASE STATEMENT

Volunteer/Intern Applicants with ABILITIES FIRST, INC. are herewith notified that the agency is required to admit program participants into each of its programs, without regard to their health status. Therefore, it is possible that a Volunteer/Intern of this agency will, during the course of their internship, be exposed to program participants who are infected with contagious diseases. This notice serves to make you aware of this possibility. Additionally, if you are a volunteer/intern by this Agency you will be trained on methods of protecting yourself and others from contagious diseases.

I have read the above and understand that this statement will be reviewed further upon hire.

APPLICANT_____DATE_____

HEALTH PRECAUTIONS/PPD
TUBERCULOSIS TESTING

As a prospective Volunteer/Intern of ABILITIES FIRST, INC. I understand that I am expected to have a Mantoux skin test/PPD done upon hire and annually thereafter. I understand that ABILITIES FIRST will be responsible for the cost of the PPD test and reading as long as I participate in the agency-sponsored programs. If I choose to have the Mantoux skin test done by my own physician or elsewhere, I understand I am responsible for the associated costs.

Employees and Volunteers/Interns who have tested positive are not required to have a PPD done. However, they are expected to have a chest x-ray done every three years. A physician's note will be accepted if there is a medical reason as to why the x-ray should not be done. Anyone who has had a positive reaction to the Mantoux test will, on an annual basis receive a health service form "signs and symptoms of Tuberculosis," to be completed and reviewed by either a physician or a nurse.

SIGNATURE_____DATE_____

March 16,1978/Revised April 1, 1990/Reviewed January 1, 2011

Rev 12/14

EDUCATION

High School	Years Completed	Diploma/Degree	Course of Study	Specialized Training
College/University				
Graduate/Professional				
Trade/Technical/Other				
Honors Received		State any additional information you feel may be helpful to us in considering your application		

EMPLOYMENT EXPERIENCE

Start with your present or last job. Include military service assignments and volunteer activities. Exclude organization names which indicate race, color, religion, national origin, age, marital or veteran status, sex, sexual orientation, gender identity, disability, the presence of non-job-related medical condition or handicap or any other basis of discrimination prohibited by law.

Employer:	Employed From	Employed To	Work Performed
Address:	Telephone #	Job Title	Supervisor
Reason For Leaving	Starting Wage	Final Wage	Other Comments:

Employer:	Employed From	Employed To	Work Performed
Address:	Telephone #	Job Title	Supervisor
Reason For Leaving	Starting Wage	Final Wage	Other Comments:

Employer:	Employed From	Employed To	Work Performed
Address:	Telephone #	Job Title	Supervisor
Reason For Leaving	Starting Wage	Final Wage	Other Comments:

Special Skills and Qualifications: Summarize special skills and qualifications acquired from employment or other experience.

CONDITIONS OF VOLUNTEER/INTERN OPPORTUNITIES

(Please read carefully)

1. I hereby declare that I am capable of performing the essential duties required of this position and understand that reasonable efforts will be made to accommodate restrictions in compliance with standards governing civil rights.
2. If I am offered a Volunteer/Intern opportunity, I agree to submit to a medical examination (for positions which require this) before starting work. If accepted into the program, I also agree to submit to a medical examination or drug test at any time deemed appropriate by ABILITIES FIRST, INC. and as permitted by law and the applicable (if any) collective bargaining agreement. I consent to such examinations and tests, and I request that the examining doctor disclose to ABILITIES FIRST, INC. the results of the examination, which results shall remain confidential and segregated from my personnel file. I understand that my acceptance and continued participation these programs, to the extent permitted by law, is contingent upon satisfactory medical examinations and drug tests, and if I am accepted into a volunteer program it will be a condition of my acceptance that I abide by the Agency's drug and alcohol policy.
3. As a potential volunteer/intern, I agree to protect the privacy of the participants Protected Health Information (PHI) and not to disclose such confidential information to others as outlined in the following Confidentiality Statement.
4. I hereby authorize Abilities First, Inc. or it's Agent thereof, to make any inquiries into my past criminal history record, if any, that reasonably relate to fitness to perform a particular job or bondability. This includes the NYS Justice Center, the Statewide Central Registry, and the Office of Inspector General's database for individuals excluded or sanctioned from participating in Medicare, Medicaid, or other Federally funded programs. If sanctioned, I understand I will be ineligible for volunteer programs and/or employment.

_____ _____

Signature of Applicant Date

CONFIDENTIALITY STATEMENT
FOR VOLUNTEERS/INTERNS

As a volunteer at ABILITIES FIRST, INC. I understand that I may be privy to or have access to confidential information regarding clients/consumers, agency proprietary information, or agency operations. By signing below, I agree not to disclose any of this information to anyone outside the agency or to individuals within the agency (who may not be in a need to know position). This obligation to maintain confidentiality extends beyond separation from the agency.

Specifically, I understand that under HIPAA (Health Insurance Portability and Accountability Act), I am obligated to adhere to the following restrictions:

- Information from individual consumer files must not be copied or divulged to anyone.
- Information gained during the course of conversations regarding individual consumers must not be divulged to anyone.
- Discussions regarding confidential information must be kept to a minimum and in a secure location where such discussions cannot be overheard by others not in a need to know position.
- Information gained while working among confidential information (or within earshot of others conversations) must be kept confidential.
- Confidential information may not be used for any purpose other than agency business.
- Confidential information may not be used for personal gain.
- Only authorized staff have access to files.
- Files are to be locked when authorized staff are not present.
- Offices containing confidential information must be shut (and locked if necessary) when authorized staff are not present.
- Individual computers must be secured and not accessible by others.
- Individual passwords must not be shared.
- Computer screens must not face the door unless there is a scrambler on the screen.

Further, I understand that it is the responsibility of each and every one of us to ensure the privacy and confidentiality of consumers and their files and will report any violations that I observe.

NAME DATE

*Approved by HIPAA Subcommittee on 10/16/02.