

EPWORTH

Where Kids Find Strength

MISSION STATEMENT:

To help youth and families find strengths, break through obstacles and build brighter futures.

VOLUNTEER APPLICATION

Margaret Mahan - Volunteer Coordinator
Epworth Children & Family Services
110 North Elm Avenue, St. Louis, MO 63119
Phone: (314)918-3330 Fax:(314)961-3503
mmahan@epworth.org

EPWORTH VOLUNTEER PROCESS

Thank you for your interest in volunteering at Epworth. The following is a brief overview of who our kids are and the process to become an Epworth volunteer, mentor or tutor:

Please fax, mail or email the starred items to the Volunteer Coordinator:

- *Completed Application with references, addresses, and e-mails
- *Interview Form
- *Signed Policy Waivers A,B & C*
- *Family Care Safety Registry (register at [www. http://www.dhss.mo.gov/safety/fcsr/](http://www.dhss.mo.gov/safety/fcsr/))
- *T B Test Results
- *Health form completed by physician
- *Other forms may be required depending on volunteer position

Meet with us for an interview and tour the campus. Find out about the different programs we offer, and then we can determine how to meet your needs as a volunteer. We'll photocopy your driver's license and auto insurance card (mentors only), and make you a volunteer photo ID badge.

When all paperwork is returned and your background checks are completed, you'll be introduced to our staff and we'll schedule your volunteer opportunity.

Please feel free to call anytime if you have questions.

Thank you so much,

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A LEGACY OF HOPE

At first they came by train – Civil War Orphans who were lost, bewildered and hungry. During the Great Depression, their parents brought them seeking safe haven. Each child and parent came praying for someone to give them hope.

Today they come with broken and angry hearts. They are lost, bewildered, alone and hungry. They are weary and wary, longing for someone to help them find their strength and a brighter future.

At Epworth, we strengthen them physically, emotionally and spiritually.

We reunite them with their families whenever possible. And, we teach them as young adults to live independently and successfully in the community.

Where there is anger and doubt, Epworth manages conflict and teaches self-esteem. When teens are forced out of other schools for unacceptable behavior, we provide therapeutic services along with their educational requirements.

Where there is no love, we provide warmth and safety.

Where there is no hope, Epworth builds confidence and self-esteem.

When there is no place else to turn...there is Epworth.

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VOLUNTEER APPLICATION (PAGE 2)

Have you ever been convicted of a misdemeanor or a felony? Yes _____ No _____

If yes, please explain:

Please list any interests or skills that you would be interested in sharing:

Do you know any volunteers or employees at Epworth? _____

How did you hear about volunteering at Epworth? _____

REFERENCES: *Please print the following information clearly.*

Please list three adults, not relatives, who have known you for at least one year.

1. _____
Name *Street Address*
_____ *E Mail*
Phone

2. _____
Name *Street Address*
(_____) _____ *E Mail*
Phone

3. _____
Name *Street Address*
_____ *E Mail*
Phone

IN CASE OF EMERGENCY NOTIFY:

Name *Relationship* *Phone*

I hereby affirm that my answers to the foregoing questions are true and correct to the best of my knowledge and I understand that false statements on this application shall be considered sufficient cause for termination from the volunteer program. I hereby give my consent for reference checks, a criminal records check and a child abuse hotline check with the applicable governmental agencies.

Applicant's Signature: _____ Date _____

VOLUNTEER INTERVIEW FORM

Date _____

NAME _____

Which of our programs interests you? _____

Why are you interested in that program? _____

How do you see yourself interacting with the kids at Epworth? _____

How will you know when you have been successful ? _____

How do you spend your free time? _____

Please share any other information you feel is pertinent: _____

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A.

SMOKING, DRUG, AND WEAPONS VOLUNTEER POLICY WAIVER

Epworth Children & Family Services is a smoke free, drug free, and weapon free agency. This means the following:

- Smoking is not permitted on any Epworth property or in any Epworth building or vehicle. Likewise, volunteers are not permitted to smoke in the presence of Epworth clients, regardless of location.
- The unlawful manufacture, distribution, dispensation, possession, being under the influence of, or use of drugs/alcohol is prohibited on or in Epworth property, while providing services on behalf of Epworth, or in the presence of Epworth clients. The violation of this rule by an employee will result in termination. Likewise, any volunteer found with any narcotic or alcoholic stimuli (unless prescribed to them by a physician) in his/her possession while functioning in the role of volunteer will be subject to termination. Volunteers must notify the agency of any criminal drug/alcohol statute conviction no later than five (5) days after conviction. Failure to do so will result in termination.
- Weapons are not permitted on or in Epworth property. Likewise, at no time shall a volunteer use or possess a weapon in the presence of an Epworth client. At no time shall a volunteer provide any Epworth client with access to a weapon.

I HAVE READ AND UNDERSTAND THIS POLICY.

Signature

Date

Printed name

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B.

LIABILITY RELEASE /PHOTO PERMISSION POLICY WAIVER

Date _____

Name _____

I AM AWARE that volunteering for the programs of Epworth Children & Family services (hereinafter referred to collectively as “Epworth”) involves risks associated with volunteer service.

I HEREBY RELEASE, discharge, indemnify and hold harmless Epworth and its assigns, successors, agents, staff, officers, board of directors, employees, contractors, and representatives, from any and all claims, causes of action, or demands of any nature or cause whatsoever, including costs and attorney fees, arising directly or indirectly out of our relating to volunteer work with Epworth.

THIS RELEASE is effective for me, my personal representatives, assigns and heirs.

I FURTHERMORE give Epworth permission to photograph me. I understand that Epworth has permission to use these photographs for publicity purposes, unless written notice is received to the contrary.

I HAVE READ AND UNDERSTAND THIS POLICY.

Signature

Date

Printed Name

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C

CONFIDENTIALITY VOLUNTEER POLICY WAIVER

I understand that in my role as a volunteer I will discover and be made aware of personal information regarding youth and families receiving services from Epworth. I further understand that I am to be discreet with this sensitive, personal information. A child’s background, problems, personal life, and other formation are to be discussed only with appropriate Epworth staff or volunteers and/or in the context of related Epworth supervision or training. I understand that the privacy of Epworth clients must be respected and protected at all times

Under no circumstance will I take photographs, videos or use other media to create images of youth at Epworth.

I understand that if an Epworth youth shares with me personal information that suggests that he/she has been the victim of abuse or neglect of any sort or has any wish, plan or intention to harm him/herself or others, I must Immediately report such information to Epworth staff responsible for the youth’s care and document this report in writing.

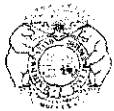
I have read Epworth policy 6:03 (Confidentiality) and understand that for the purposes of this policy, my responsibilities regarding confidentiality are equivalent to those of an employee. I will abide by this policy in my work as a volunteer.

I HAVE READ AND UNDERSTAND THIS POLICY.

Signature Date

Printed name

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RESET

WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to **Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.**

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- Adoptive Parent (Agency Name: _____)
- Child Care
- Foster Parent/Family Member of Foster Parent (County Office: _____)
- Hospital
- Long Term Care/Personal Care (Please choose subcategory at right →.)
- Mental Health/Psychiatric Hospital
- Voluntary (Select voluntary if no other registration type applies.)

Long Term Care / Personal Care Subcategories
(Complete if LTC/PC selected at left.)

- Adult Day Care
- Assisted Living Facility
- Hospice
- Hospital LTAC/Swing Bed
- Mental Health – Residential Facility/ICF
- Nursing Facility/Skilling Nursing
- Personal Care – Home Health
- Personal Care – In-Home Services
- Personal Care – Consumer Directed Services/Center for Independent Living
- Personal Care – HCY/PDW/DDD/Other

A one-time registration fee of **\$10.00** applies to all categories except Foster Parents. Foster Parents must list the agency or county office.

Register only once. If you believe you have already registered, check our website at www.health.mo.gov/safety/fcsr or call, toll free, 866-422-6872.

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

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PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (If applicable.)
OTHER NAMES USED (If applicable. Include other last names, other first names, nicknames.)		DATE OF BIRTH (mm/dd/yyyy)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F

CONTACT INFORMATION

STREET ADDRESS (Must be different from Employer Street Address.)

ADDRESS LINE 2 OR PO BOX (If applicable. This line of the address must reflect where you receive your mail.)

CITY	STATE	ZIP CODE	COUNTY
TELEPHONE () -	EMAIL (Optional)	COUNTRY (Complete only if U.S. territory or outside U.S.)	

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

<input type="checkbox"/> My current/potential child care, long term care or mental health care employer is:	<input type="checkbox"/> No Employer, because I am a(n):
EMPLOYER NAME	<input type="checkbox"/> Adoptive Parent
EMPLOYER STREET ADDRESS	<input type="checkbox"/> Foster Parent/Family Member
EMPLOYER CITY	<input type="checkbox"/> Home Child Care Provider
STATE	<input type="checkbox"/> Private Pay/Private Duty
ZIP	<input type="checkbox"/> Student
EMPLOYER TELEPHONE () -	<input type="checkbox"/> Volunteer
EMPLOYER CONTACT NAME	<input type="checkbox"/> Other (Explain: _____)
EMPLOYER CONTACT TITLE	

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requestor of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT (Must be signed in blue or black ink.) **DATE OF SIGNATURE (Must be within six months of submission.)**

➤ _____ / /

WHAT IS THE FAMILY CARE SAFETY REGISTRY?

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002 as a personal care worker, or hired on or after January 1, 2009 as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. **Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor.** Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?

Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select "Voluntary." (A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 *et seq.*, RSMo.) If you checked Long Term Care / Personal Care, please *also* make one or more selections from the column on the right for subcategory.

Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

Contact Information – List your address including street address, any post office box or other identifying mailing address information, city, state, ZIP code, and county. Include your telephone number. We will use this information to notify you of registration results and any background screenings conducted.

Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requestors for employment purposes, as provided in §210.921.1, RSMo.

Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right.

WHERE DO I SEND MY REGISTRATION FORM?

Send your completed registration form and photocopy of Social Security card and required fee to the **Missouri Department of Health and Senior Services, Family Care Safety Registry, P.O. Box 570, Jefferson City, MO, 65102**. If you have questions, please call the Registry using the toll-free telephone number, **866-422-6872**.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requestor, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your mailing address. You can send address changes to Family Care Safety Registry, P.O. Box 570, Jefferson City, MO, 65102.

WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?

As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the *transfer* of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the *substance* of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. A Registry worker will first confirm whether the person in question is registered. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION
MEDICAL EXAMINATION REPORT FOR CAREGIVERS AND STAFF

Patient may: Have contact with children (infant through school-age) in care away from their own homes.
 Be responsible for children's physical care and social development during day and/or nighttime hours.
 Need to lift children.

IDENTIFYING INFORMATION (To be completed by patient.)

NAME	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER ()

NAME AND ADDRESS OF CHILD CARE FACILITY WHERE EMPLOYED

MEDICAL REPORT (To be completed by a licensed physician or advance practice nurse; by registered professional nurse or registered nurse who is under the supervision of a licensed physician.)

PHYSICAL EXAMINATION	On _____ (date), I examined this patient. I certify that to the best of my knowledge, this patient is in good physical and emotional health and free of contagious disease. <input type="checkbox"/> YES <input type="checkbox"/> NO
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TB CLEARANCE	(Check one.) <input type="checkbox"/> Negative tuberculin (TB) skin test results dated _____ <input type="checkbox"/> A chest x-ray or appropriate written follow-up of a previous examination that indicates the individual is free of contagion dated _____
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LIMITATIONS	The above dated physical examination indicates this patient has the following physical or mental conditions that might endanger the health of children or might prevent the patient from providing adequate care of children: <input type="checkbox"/> None <input type="checkbox"/> _____
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RESTRICTIONS	This patient has the following restrictions, e.g. cannot lift children who weigh more than 20 pounds, etc. <input type="checkbox"/> None <input type="checkbox"/> _____
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REMARKS

SIGNATURES

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT.)
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NAME AND ADDRESS OF CLINIC, GROUP PRACTICE, OTHER (PLEASE USE STAMP, IF AVAILABLE.)	IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME. (PLEASE PRINT.)
	TELEPHONE NUMBER ()