Domestic Violence
Sexual Assault
Child Abuse Prevention

Our Name is
Our Mission

Helping children and families heal since 1972

Domestic Violence Sexual Assault Program
Advocacy · Counseling
Education · Support
Safe Shelter
24-Hour Crisis Line
452-HELP

Child Abuse Prevention Program
Support · Education
Early Family Support Services

Children's Advocacy Center
Family Support Services
Forensic Interviewing
Facility

1210 East Front Street
Suite C
Port Angeles
Washington
98362-4325

Phone: 360-452-3811
Fax: 360-452-8243
www.healthyfam.org

A United Way Agency

Board Application Packet

Please return to:

Tracy Caldwell, Deputy Executive Director
Healthy Families of Clallam County
1210 E. Front St., Suite C
Port Angeles Wa 98362-4325

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JOB DESCRIPTION FOR BOARD MEMBERS

Directors are selected because of their commitment to the agency's mission and their capacity to significantly contribute to its fulfillment. The Board is ultimately responsible for the agency's well-being, effectiveness, and solvency, and assures that it stays focused upon achieving its mission.

Collectively, the Board of Directors:

- Defines the agency's mission and sets its policies and priorities;
- Establishes organizational goals and plans, and monitors and evaluates the agency's performance to assure the continuing and effective pursuit of its mission;
- Generates financial and other resources required to achieve the mission; sets financial policies; approves and monitors agency budgets; and assures financial accountability;
- Hires, evaluates, and oversees the agency's Director;
- Recruits, trains, develops, assesses, and deploys Board members; and
- Advocates for, and promotes public awareness and support of the agency and services.

Individually, Board members are expected to:

- Demonstrate a strong commitment to the agency as an effective, worthy organization deserving of their time, efforts and financial support – and the support of others;
- Evidence that commitment by active participation in Board and Committee meetings and agency functions; by volunteering time, talents, and resources; and by taking initiative as needed;
- Commit sufficient time for effective Board service, for attendance at Board Meetings and for active service on at least one Board Committee;
- Become well-informed about the agency's history, services, funding, finances, personnel, needs, challenges and vision, and to actively share that information within our community;
- Support the agency by contributing to it generously, and by actively working to generate, additional resources. It is generally expected that each member will:
  --"give or get" annual donations, commensurate with their capacities;
  --assist in at least one special fundraising event each year; and
  --use their contacts and networks to solicit or involve major donor, foundation, business, club or other prospects; and
- Avoid conflicts of interest, and maintain the confidentiality of agency information.

Directors are insured for $1 million against liability by an "errors and omissions" policy.

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Board Profile Questionnaire

1. Please describe yourself. We'd like a short paragraph highlighting:

- Your background
- Your city of residence
- Your job, if you work outside your home
- Any special interests
- Any significant organizational affiliations or other volunteer commitments
- Any special honors you've received, etc.
- Anything else you would like us to know about you

This information will be used to prepare a "Board Profile" that is used in our annual report and routinely distributed to funding sources, donors and consumers of our services.

Please also provide us with the following information for inclusion in our list of Board members, which is distributed to other Board members and staff.

Mailing Address:____

____

Day Phone: ________________ Evening Phone: ________________

Fax (if any): ________________ E-Mail: ______________________

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ACCESS AND CONFIDENTIALITY AGREEMENT INCLUDING ELECTRONIC TRANSMISSION

Employees, volunteers, and student interns with privileges at Healthy Families, may have access to what this agreement refers to as "confidential information." This is defined as information, written, spoken or electronically transmitted, whose unauthorized or indiscreet disclosure could be harmful to the interests of Healthy Families, it's employees, Board of directors or clients/parents.

Confidential information includes client/member information, employee/volunteer/student information, financial information, other information relating to Healthy Families and information proprietary to other companies or persons. Access to confidential information may be through a computer system or employment activities. Any outgoing confidential information will be clearly marked confidential.

Confidential information is valuable, sensitive, protected by law, and by strict Healthy Families policies. The intent of these laws and policies is to assure that confidential information will remain confidential, that is, it will be used only as necessary to accomplish the organization's mission. Confidential information and files will not be removed from the agency except under certain exceptional conditions, logging out the file, receiving written permission from the Supervisor and providing notification to the Executive Director.

Employees, volunteers, and student interns are required to conduct themselves in strict conformance to applicable laws and Healthy Families policies governing confidential information. Principal obligations in this area are explained below. Employees, volunteers, and student interns are required to read and to abide by these duties. The violation of any of these duties will result in discipline, which might include, but is not limited to, termination of employment and to legal liability.

Employees, volunteers, and student interns will have access to confidential information that may include, but is not limited to, information relating to:

- Clients/members (such as records, conversations, admittance information, client/member financial information, etc.),
- Employee/volunteers/students (such as salaries, employment records, disciplinary actions etc.)
- Healthy Families information (such as financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary computer programs, source code, proprietary technology, etc.) and third party information (such as computer programs, client and vendor proprietary information source code, propriety technology, etc.).

Accordingly, as a condition of and in consideration of access to confidential information, I promise that:

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1. I will only access confidential information only as needed to perform my legitimate duties as an employee/volunteer/student affiliated with Healthy Families, this means, among other things that:

   A. I will only access confidential information for which I have a need to know; and
   B. I will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information except as properly authorized within the scope of my professional activities affiliated with Healthy Families; and
   C. I will not misuse confidential information or carelessly handle confidential information.

2. I will safeguard and will not disclose my access code or any other authorization I have that allows me to access confidential information.
3. I accept responsibility for all activities undertaken using my access code and other authorization.
4. I will report activities by any individual or entity that I suspect may compromise the confidentiality of confidential information, reports made in good faith about suspect activities will be held in confidence to the extent permitted by law, including the name of the individual reporting the activities.
5. I understand that my obligation under this agreement will continue after termination of my employment. I understand that my privileges are subject to periodic review, revision and if appropriate, renewal.
6. I understand that I have no right or ownership interest in any confidential information referred to in this agreement. Healthy Families may at any time revoke my access code, other authorization, or access to confidential information. At all times during my employment, I will safeguard and retain the confidentiality of all information.
7. I will be responsible for any misuse or wrongful disclosure of confidential information and for any failure to safeguard my access code or other authorization access to confidential information. I understand that my failure to comply with this agreement may also result in loss of employment at Healthy Families.

______________________________ ____________________
Employee/Volunteer/Student Signature Date

____
Printed Name

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ASSURANCE OF CONFIDENTIALITY

As an employee, intern, volunteer or acting in any other capacity in connection with Healthy Families of Clallam County, I agree to the following:

1. All charts, notes and other written material concerning clients will be locked up when I am not using them. I understand staff may not remove confidential client files from the agency except under certain exceptional conditions, logging out the file, receiving written permission from their Supervisor and providing notification to the Executive Director.
2. Discussion regarding clients will be held in staff offices or other places, which assure privacy.
3. No privileged information about clients will be discussed with family and/or friends.
4. For privileged information, written or verbal, to be shared with other agencies, or professionals, written authorization will first be obtained from the client.
5. Access to client files is limited to agency professionals and clerical staff. Access to client files by anyone else must be approved by the Executive Director/Agency Manager.
6. Termination of employment, training or other professional relationship with Healthy Families of Clallam County does not discontinue prohibition from disclosing information contained in client records.

_______________________________ _______________
Employee, Intern, Volunteer (circle one) Date

_______________________________ _______________
Witness Date

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PERMISSION TO OBTAIN BACKGROUND CHECK

Disclosure:

Background checks are conducted on all prospective employees and volunteers who will or may have unsupervised access to children under the age of sixteen, or to developmentally disabled, or vulnerable adults The background check is for initial employment or engagement purposes only.

I grant permission to Healthy Families of Clallam County to request a
I understand that this information is necessary to determine whether or not I am able to have unsupervised access to clients and in some cases may be necessary to determine my employment/volunteer status with Healthy Families.

____________________________ ____________________
Print Name

____________________________ ____________________
Signature Date

Healthy Families of Clallam County
1210 East Front Street, Suite C
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WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633, Olympia WA 98504-2633

REQUEST FOR CRIMINAL HISTORY INFORMATION
CHILD/ADULT ABUSE INFORMATION ACT
RCW 43.43.830 THROUGH 43.43.845

(Instructions on Reverse Side)

(A) REQUESTING AGENCY/ADDRESS

Healthy Families of Clallam County
Agency

1210 E. Front St., Ste. C
Attn

Tracy Caldwell
Address

Port Angeles Wa 98362
City/State/Zip

I certify this request is made pursuant to and for the purpose indicated.

Authorized Signature ______ Date ______

Operations Manager — (360) 452-3811
Title — Area Code/Phone Number

(B) PURPOSE

Check appropriate box

- ☐ Educational School District (ESD)/School District Volunteer – no fee
- ☒ Non-Profit Business/Organization – no fee (Excluding Schools & ESD's)
- ☐ Profit Business/Organization - $17
- ☐ Adoptive Parent - $17
- ☐ Receive results electronically

Email address ______

Password ______ (must be at least 8 characters)

Fees: Make payable to **Washington State Patrol** by check, money order, or business account.

Notary letters certifying the results are available upon request. There is an additional $5.00 processing fee per notary seal.

______ **Notarized Letter(s)**

(C) APPLICANT OF INQUIRY **(Please provide as much information as possible; name and date of birth are mandatory.)**

Applicant's Name: ______
Last First Middle

Alias/Maiden Name(s): ______

Date of Birth: ______ (Month/Day/Year) Sex: ______ Race: ______

Secondary dissemination of this criminal history record information response is prohibited unless in compliance with statute.

(D) WASHINGTON STATE PATROL IDENTIFICATION & CRIMINAL HISTORY SECTION

WSP Use Only

As of this date, the applicant named below has no record pursuant to RCW 43.43.830 through 43.43.845.

Healthy Families of Clallam County
Requesting Agency

Applicant's Signature

Applicant's Name

Address

City/State/Zip

Applicant Right Thumb Print (Optional)

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
Healthy Families of Clallam County	1210 E. Front St., Suite C, Port Angeles Wa 98362-4325	

2. NAME AND SIGNATURE OF PERSON REQUESTING THE BACKGROUND CHECK

PRINTED NAME: Tracy Caldwell 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
11001093	0712-18705	

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

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.