VOLUNTEER APPLICATION

Thank you for your interest in becoming a volunteer with Capability Health and Human Services. Please complete the following application for our volunteer opportunities. Some of the volunteer opportunities require background screening. Upon acceptance of your application, we will invite you for a brief orientation that will help you learn more about our mission, what we do and how you can help.

Should you have any questions, please contact our Volunteer Department at 702-677-3569. Thank you for offering your time and talents to support Capability Health and Human Services and the community we serve.

Please fill out every page completely.

Capability Health and Human Services
Volunteer Application
7281 W. Charleston Blvd.
Las Vegas, NV 89117
702-870-7050

Date of Application: _____

Last name: _____ First Name: _____ Middle Name: _____

Address: _____Apt. /Unit #: _____

City: _____ State: _____ Zip Code: _____

Primary phone number: _____ Secondary phone number: _____

Does your employer have a volunteer gift matching program? **YES** **NO**

Are you over the age of 18 years? **YES** **NO**

Have you ever volunteered or worked for Capability Health and Human Services before?
YES **NO**

If yes, please give dates: Volunteered: _____ Worked: _____

Have you ever been convicted of a crime? **YES** **NO**
(A conviction will not necessarily disqualify you.)
If yes, please explain: _____

_____

_____

Is anyone related to you employed by Capability Health and Human Services?
YES **NO**

If yes, please give their name: _____ and relationship to you: _____

On what date would you be available to start volunteering? **_____/_____/_____**

In case of emergency, please contact:

Name: _____

Address: _____

City: _____

Contact Phone Number(s) _____

Which days and hours are you available to volunteer? Fill in the chart below.

Days and Hours Available:

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM							
PM							

Please list any academic honors, scholarships, offices held, etc.

_____
_____
_____

Describe any specialized training, apprenticeships, licenses or skills:

_____
_____
_____

REFERENCES:

Please list professional and/or personal references below. We will be reaching out to these references for certain volunteer opportunities.

Reference Type	Name	Address	Phone Number	Relationship / Occupation / title	Years Known
BUSINESS					
BUSINESS					
PERSONAL					

Note: Some of our volunteer opportunities require that the volunteer possess the following:
(*Please answer yes or no for each question.)*

Reliable Transportation **YES** **NO**

A Valid Nevada Drivers License **YES** **NO**

Proof of Current Vehicle Registration **YES** **NO**

Proof of Vehicle Insurance **YES** **NO**

Please respond to the following questions as completely as you can. Please use complete sentences.

1. Are you willing to submit to the following as a condition of volunteering with Capability Health and Human Services?

State fingerprinting	**YES**	**NO**
Federal fingerprinting	**YES**	**NO**
Background check	**YES**	**NO**
Drug screening	**YES**	**NO**

2. How did you hear about Capability Health and Human Services and why do you want to volunteer here?

_____

_____

_____

_____

_____

_____

_____

3. What type of volunteer work are you interested in?

_____

_____

_____

_____

4. Have you had any personal experiences in your life that have increased your awareness and understanding of people with limited abilities?

_____

_____

_____

_____

5. What are your special hobbies or interests?

_____

_____

_____

_____

_____

VOLUNTEER ACKNOWLEDGEMENT
***********PLEASE READ CAREFULLY BEFORE SIGNING*****

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I hereby give Capability Health and Human Services and/or any qualified physician or emergency medical personnel permission to secure appropriate emergency medical treatment for me, to the full extent permitted by law.

AUTHORIZATION FOR PROMOTION AND PUBLICITY RELEASE

I do hereby authorize Capability Health and Human Services, its agents and representatives to take and use promotional publicity photos, films, video, or other media for use in authorized promotion or publicity activities, understanding that there are no monetary benefits involved.

VOLUNTEER TERMS

I understand that the relationship between Capability Health and Human Services and volunteers is an "at will" arrangement, and it may be terminated at any time without cause by either the volunteer or Capability Health and Human Services. I am responsible for information Capability Health and Human Services of ANY changes regarding information contained in the application, and I am responsible for following and abiding by the Volunteer code of conduct.

POLICIES and PROCEDURES

1. I agree to comply with the rules, regulations, standards, policies and procedures of Capability Health and Human Services at all times. I understand that the rules, regulations, policies and procedures may be found in Capability Health and Human Services Volunteer Handbook and that it is my responsibility to familiarize myself with these policies.

2. I understand that, in the course of volunteering with Capability Health and Human Services, I may have access to Capability Health and Human Services client, employee, member, volunteer or other information concerning Capability Health and Human Services activities and operations and that such information is strictly confidential and may not be discussed publicly or privately.

3. Capability Health and Human Services is a drug-free workplace in accordance with the Drug Free Workplace Act of 1988 and;

4. Capability Health and Human Services is a smoke-free work place and that smoking inside any Capability Health and Human Services vehicle or building is prohibited.

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ABOVE STATEMENTS. I understand that failure to follow the regulations, standards, policies and procedures of Capability Health and Human Services is grounds for immediate termination of volunteer status and may disqualify me from obtaining employment (paid position) with Capability Health and Human Services in the future.

_____ _____

Signature of Applicant **Date**

_____

Print Name of Applicant

AUTHORIZATION FOR RELEASE OF INFORMATION FOR CREDIT/ CRIMINAL HISTORY

I hereby authorize LexisNexis (formerly ChoicePoint Services Inc.), on behalf of Capability Health and Human Services, to provide information regarding my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, and/or mode of living. This information may be compiled from credit bureaus, court records repositories, departments of motor vehicles, past or present employers and educational institutions, governmental occupational licensing or registration entities, business or personal references, and any other source required to verify information that I have voluntarily supplied. I understand that I may request a complete and accurate disclosure of the nature and scope of the background verification to the extent such investigation includes information bearing on my character, general reputation, personal characteristics and/or mode of living.

_____ _____

Applicant Signature **Date**

PLEASE COMPLETE THE FOLLOWING INFORMATION:

_____ _____

Last Name First Name

_____ _____

Other Last Names Other First Names

_____ _____

Current Address: Number & Street Apt. / Unit #

_____ _____ _____

City State Zip Code

(___ ___) _____

Telephone

_____ _____ Male ( ) Female ( )

Social Security Number Date of Birth Gender

_____ _____

Driver's License Number State of Issue (NV, CA, AZ, etc.)

_____

In the list below, please circle those states where you have resided for more than 30 consecutive days:

AL AK AZ AR CA CO CT DE DC FL GA HI ID IL IN IA KS KY

LA ME MD MA MI MN MS MO MT NE NV NH NJ NM NY NC ND

OH OK OR PA RI SC SD TN TX UT VT VA WA WV WI WY

Contract Provider Application
Supplemental Questions

Capability Health and Human Services is a certified and/or approved contract provider of the Nevada Developmental Services (DS) Regional Center. The Nevada DS Regional Centers require that all employee applicants complete the following questions:

1) Have you ever worked with or volunteered for any agency which contracts with the State of Nevada Developmental Services Regional Centers (Desert, Rural or Sierra Regional Center)? ☐Yes ☐No

2) Have you ever worked at or volunteered for an agency, either within or outside of, the State of Nevada that serves a vulnerable population e.g. children, seniors or developmentally disabled? ☐Yes ☐No

3) Have you ever been the accused (placed on re-assignment/administrative leave) in an abuse, neglect or exploitation complaint and/or investigation? ☐Yes ☐No

   If so, were the accusations confirmed or substantiated? ☐Yes ☐No

   If yes, what was the out come? (*Check all that apply*.)

   ☐Termination ☐Suspension ☐Retraining ☐Other

   Describe: _____

I declare that the information provided to the above questions is true and complete.

_____ _____

Print Name Signature

_____

Date