Camp Amanda
2023 New Volunteer Application

Friday, July 28th - Sunday, July 30th

Camp Amanda is a free camp for grieving children ages 7 to 14 where campers are paired with their own camp counselor for a special weekend experience. This carefully designed program helps children begin to talk about their feelings related to a death of someone special, and teaches them coping skills for dealing with those feelings. Camp Amanda a program of Walla Walla Community Hospice.

Please return application to:
1067 E. Isaacs Avenue,
Walla Walla, WA 99362

Please complete application entirely. Incomplete applications will not be accepted.

***COVID-19 vaccination required ***

Volunteer Information

Name *(first/last)*: **Gender:** **Date of Birth:**

Preferred Name for Name Tag *(if different)*:

Home Address: **City/State:** **Zip:**

Mailing Address: **City/State:** **Zip:**

Phone Number: ***Primary:*** ***Secondary:***

E-mail address *(most information is sent via e-mail)*:

Best time of day to reach you: ☐ *9am - 12pm* ☐ *12pm - 3pm* ☐ *3pm - 6pm* ☐ *Other:*

T-shirt Size: ☐ XS ☐ S ☐ M ☐ L ☐ XL ☐ 2XL ☐ 3XL

Non-Food Related Allergies: ☐ None

Allergic reaction:

Food Allergies: ☐ None

Allergic reaction:

Food intolerances: ☐ None

Do you know anyone who has been a camper or volunteered at Camp Amanda? If so, who? ☐ No one

How did you hear about Camp Amanda?

Emergency Contacts

Contact #1 Name *(first/last)*: **Relationship:**

Phone(s) ***Primary:*** ***Secondary:***

Contact #2 Name *(first/last)*: **Relationship:**

Phone(s) ***Primary:*** ***Secondary:***

Questions? Contact Luci Berg, Camp Amanda Coordinator at:
***office 509.525.5561 /* cell + text** 509.540.8313 / campamanda@wwhospice.org / www.wwhospice.org/campamanda

Employment/Education

Education *(school(s)/year(s) graduated/degree(s) earned*:

(or retired from)
Current Employer: **Position:**

Volunteer Information

Which Camp Amanda volunteer role(s) are you interested in?
-- Check all that apply --
**Please consider that Camp Counselors are committed to attending evening Camp Amanda pre-meeting 1 week before camp and Camp Amanda Reunion on February 24, 2024.*

☐ Camp Counselor*	☐ Floater/Runner *(during camp)*	☐ Archery *(Blue Mt. Archery Club only)*
☐ Kitchen Crew	☐ Preparation *(prior to camp)*	☐ Certified Lifeguard
☐ Crafts	☐ Clean Up *(following camp)*	
☐ Other:		

Comments:

Do you have any previous volunteer history? If so, what? ☐ *Check here if none*

Why do you want to volunteer for Camp Amanda?

Educational background, skills, talents, interests, or training that may be helpful as it relates to your position at camp?

This question is **OPTIONAL:*
****Do you have any restrictions that you would like us to consider when making your volunteer placement**?
(ex: hearing/sight/back problems/etc.)

Volunteer Information *(continued)*

We will have an orientation day before Camp Amanda. Is there any other type of support do you think you will need in order to be successful in your role at Camp Amanda? ☐ None

Any other questions or concerns about volunteering for Camp Amanda? ☐ None

Your Grief History

Have you had the experience of losing a loved one to death? *Please tell us who/when/how.* ☐ None

Do you have any concern that Camp Amanda may affect your past or current grieving processes? ☐ None

References

Please list 3 personal (only <u>one</u> family member)/professional references.

Name *(first/last)*: **Relationship:**

E-mail address *(preferred):*

Phone(s) ***Primary:*** ***Secondary:***

Name *(first/last)*: **Relationship:**

E-mail address *(preferred):*

Phone(s) ***Primary:*** ***Secondary:***

Name *(first/last)*: **Relationship:**

E-mail address *(preferred):*

Phone(s) ***Primary:*** ***Secondary:***

Participation Commitment

Please initial next to each section to show you have read and understand, and agree to commit to the following statements:

_____ New Camp Amanda volunteers attend a pre-meeting orientation 2 to 3 weeks before Camp Amanda at the WWCH office.

_____ Camp Amanda volunteers must be available to attend camp weekend from Friday at 3pm until Sunday at 5pm.

_____ Camp Amanda Camp Counselors are required to attend a camp reunion on a Saturday in the February following camp. *The reunion is considered the closure to Camp Amanda, and having Camp Counselors in attendance is important to the campers. Families are promised that counselors will be in attendance, and it may come as another loss if their counselor is not there. Camp Amanda 2023 Reunion is planned to be 02/24/2024*

Authorization, Liability Release & Hold Harmless Agreement

Please initial next to each section to show you have read and understand, and agree to commit to the following statements:

_____ Walla Walla Community Hospice has permission to use photographs taken of me during camp in the promotion and publicity of Camp Amanda

_____ I will assist in observing the rules of the camp.

_____ I understand that participation in activities, such as those available at Camp Amanda, carries with it the risk of physical injury, including but not limited to, bruises, cuts, sprains, broken bones, dislocations, concussions and the potential for other serious injuries, including paralysis or death. I am aware of the dangers and have sufficient physical ability to safely participate as a volunteer at the camp. I further agree to assume all the risk of injury or death associated with the programs at the camp and I release and hold harmless Walla Walla Community Hospice, its employees, officials, agents, representatives and volunteers from any liability resulting in damages to me or my property caused from ordinary negligence of Walla Walla Community Hospice, its employees, agents, representatives and volunteers, which arise in connection with my participation as a volunteer. I further agree to release, hold harmless, and defend Walla Walla Community Hospice from any claims which arise from are caused by, or result from my own negligent or intentional act or omission that occurs during my participation as a volunteer.

By signing below, I acknowledge that I have read, understood, and do hereby accept the conditions of this AUTHORIZATION, LIABILITY RELEASE, & HOLD HARMLESS AGREEMENT, as printed above.

I hereby certify that the statements made on this application are true and correct to the best of my knowledge. I understand that, by submitting this application I authorize inquiries to be made concerning my employment, character and public records for the purpose of determining my suitability as a volunteer.

I acknowledge that I have also read the Participation Commitment, and to the best of my knowledge, I can attend the orientation, and the Camp Amanda Reunion.

Signature ***Printed Name*** ***Date***

When completed, you can either:

- **print & mail** to WWCH office (1067 E . Isaacs Ave., Walla Walla, WA 99362)
  OR
- **e-mail to Camp Amanda Coordinator by** saving this PDF, attaching it to an e-mail and sending it to campamanda@wwhospice.org

WALLA WALLA COMMUNITY HOSPICE
DISCLOSURE STATEMENT

Pursuant to the requirements of Chapter RCW 43.43, we must ask you to complete the following disclosure statement. This information will be maintained in accordance with state law.

Have you ever been convicted of any of the following crimes against children or other persons, or crimes related to drugs:

YES	NO		YES	NO	
_____	_____	Aggravated murder	_____	_____	Child abuse or neglect as defined in RCW 26.44.020
_____	_____	First or Second degree murder	_____	_____	First or Second degree of custodial interference
_____	_____	First or Second degree kidnapping	_____	_____	First of Second degree custodial sexual misconduct
_____	_____	First, Second or Third degree assault	_____	_____	Malicious harassment
_____	_____	First, Second or Third degree assault of a child	_____	_____	First, Second or Third degree child molestation
_____	_____	First, Second or Third degree rape	_____	_____	First or Second degree sexual misconduct with a minor
_____	_____	First, Second or Third degree rape of a child	_____	_____	Patronizing a juvenile prostitute
_____	_____	First or Second degree robbery	_____	_____	Child abandonment
_____	_____	First degree arson	_____	_____	Promoting pornography
_____	_____	First degree burglary	_____	_____	Selling or distributing erotic material to a minor
_____	_____	First or Second degree manslaughter	_____	_____	Custodial assault
_____	_____	First or Second degree extortion	_____	_____	Violation of child abuse restraining order
_____	_____	Indecent liberties	_____	_____	Child buying or selling
_____	_____	Incest	_____	_____	Prostitution

_____	_____		_____	_____	
_____	_____	Vehicular homicide	_____	_____	Felony Indecent Exposure
_____	_____	First degree promoting prostitution	_____	_____	Criminal abandonment
_____	_____	Communications with a minor	_____	_____	Manufacturing a controlled substance
_____	_____	Unlawful imprisonment	_____	_____	Delivery of a controlled substance
_____	_____	Simple assault	_____	_____	Possession of a controlled substance with intent to manufacture or deliver
_____	_____	Sexual exploitation of minors	_____	_____	Or any of these crimes as they may have been renamed
_____	_____	First or Second degree criminal mistreatment			

If your answer is "yes" to any of the above, please describe and provide the date(s) of the conviction(s) and the sentence(s) imposed.

_____
_____
_____
_____
_____
_____
_____

Have you ever been convicted of any of the following crimes relating to financial exploitation of a person 60 years of age or older, who has a functional, mental or physical inability to care for himself or herself or who is a patient in a state hospital:

Yes	**No**		**Yes**	**No**	
_____	_____	First, Second or Third degree extortion	_____	_____	Forgery
_____	_____	First or Second degree robbery	_____	_____	Or any of these crimes as they may have been renamed
_____	_____	First, Second or Third degree theft			

If your answer is "yes" to any of the above, please describe and provide the date(s) of the conviction(s) and the sentence(s) imposed.

_____
_____
_____
_____
_____
_____

1. Have you ever been found in any dependency action to have sexually assaulted or exploited any minor or to have physically abused any minor?

   Yes _____ No _____

2. Have you ever been found by a court in a domestic relations proceeding to have sexually abused or exploited any minor or to have physically abused any minor?

   Yes _____ No _____

3. Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person?

   Yes _____ No _____

4. Have you ever been found in any disciplinary board final decision to have abused or financially exploited any person 60 years of age or old who has a functional, mental or physical inability to care for himself or herself or who is a patient in a state hospital?

   Yes _____ No _____

5. Have you ever been found by a court in a protection proceeding under Chapter 74.34 RCW to have abused or financially exploited a person 60 years of age of older who has a functional, mental or physical inability to care for himself or herself or who is a patient in a state hospital?

   Yes _____ No _____

If your answer is "yes" to any of questions of 1 through 5 above, please describe and provide the date(s) of the finding(s) and the penalty(ies) imposed.

_____
_____
_____
_____
_____
_____

UNDER PENALTY OF PERJURY, I certify that the above information is true, correct and complete. I understand that if I am hired, I can be discharged for any misrepresentation or omission in the above statement. I also understand that if I am hired, my employment is conditioned on your receipt of a satisfactory report from the Washington State Patrol.

Signature: _____

Name (print): _____

Date: _____

We may request your fingerprints to obtain from the Washington State Patrol criminal identification system a report of you record of criminal convictions for offenses against persons, civil adjudications of child abuse and disciplinary board final decisions. If you are hired before that report is available, YOUR EMPLOYMENT WILL BE CONDITIONED UPON THE RECEIPT OF A SATISFACTORY REPORT.

You will be notified of the State Patrol's response within ten days after we receive the report. We will make a copy of the report available to you upon your request.

Exhibit "C" *(Volunteer copy)*

Appendix A to Part 601

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act **(FCRA)** is designed to promote accuracy, fairness, and privacy of information in the files of every "consumer reporting agency" **(CRA).** Most **CRA's** are credit bureaus that gather and sell information about you-such as if you pay your bills on time or have filed bankruptcy-to creditors, employers, landlords, and other businesses. You can find the complete text of the **FCRA, 15 U.S.C. 1681-1681u,** at the Federal Trade Commission's web site (http://www.ftc.gov). The **FCRA** gives you specific rights, as outlined below. You may have additional rights under state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

- **You must be told if information in your file has been used against you.** Anyone who uses information from a **CRA** to take action against you - such as denying an application for credit, insurance, or employment - must tell you, and give you the name, address, and phone number of the **CRA** that provided the consumer report.

- **You can find out what is in your file.** At your request, a **CRA** must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the **CRA,** if you request the report within 60 days of receiving notice of the action. You also are entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, the **CRA** may charge you a fee, which shall not exceed the amount established by the Federal Trade Commission on January 1 of each year.

- **You can dispute inaccurate information with the** CRA. If you tell a **CRA** that your file contains inaccurate information, the **CRA** must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the **CRA.** (The source also must advise national **CRA's** - to which it has provided the data-of any error). The **CRA** must give you a written report of the investigation and a copy of your report if the investigation results in any change. If the **CRA's** investigation does not resolve the dispute, you may add a brief statement to your file. The **CRA** must normally include a summary of statement if future reports. If an item is deleted or a dispute statement if filed, you may ask that anyone who has recently received your report be notified of the change.

- **Inaccurate information must be corrected or deleted.** A **CRA** must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. **However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified.** If your dispute results in any change to your report, the **CRA** cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the **CRA** must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.

- **You can dispute inaccurate items with the source of the information.** If you tell anyone - such as a creditor who reports to a **CRA** - that you dispute an item, they may not then report the information to a **CRA** without including a notice of your dispute. In addition, once you've notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.

- **Outdate information may not be reported.** In most cases, a **CRA** may not report negative information that is more than seven years old; ten years for bankruptcies.

- **Access to your file is limited.** A **CRA** may provide information about you only to people with a need recognized by the **FCRA** - usually to consider an application with a creditor, insurer, employer, landlord, or other business.

- **Your consent is required for reports that are provided to employers, or reports that contain medical information.** A **CRA** may not give out information about you to your employer, or prospective employer, without your written consent. A **CRA** may not report medical information about you to creditors, insurers, or employers without your consent.

- **You may choose to exclude your name from CRA lists for unsolicited credit and insurance offers.** Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete, and return the **CRA** form provided for this purpose, you must be taken off the lists indefinitely.

- **You may seek damage from violators.** If a **CRA,** user or (in some cases) a provider of **CRA** data, violates the

FCRA, you may sue them in state or federal court.

The FCRA gives several different federal agencies authority to enforce the FCRA:

FOR QUESTIONS OR CONCERNS REGARDING:	PLEASE CONTACT:
CRAs, creditors and others not listed below	Federal Trade Commission Consumer Response Center- FCRA Washington, DC 20580 202-326-3761
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, **DC** 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, **DC** 20551 202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials **"F.S.B."** appear in federal institution's name)	Office of Thrift Supervision Consumer programs Washington, **DC** 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-518-6360
State chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Division of Compliance & Consumer Affairs Washington, **DC** 20429 800-934--FDIC
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce commission	Department of Transportation Office of Financial Management Washington, **DC** 20590 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - **GIPSA** Washington, **DC** 20250 202-720-7051

ACRANET
EMPLOYMENT SCREENING

Notice for Applicant/Employee A-4
Authorization

'Notice of Intent' and 'Authorization' To Obtain an Investigative Consumer Report for Employment or Other Legitimate Permissible Purposes

The undersigned applicant/employee is hereby notified that **Walla Walla Community Hospice** may obtain an investigative consumer report for employment purposes through ACRAnet. Such report may include information as to character, general reputation, history of criminal convictions, employment, education, professional license, credit and/or driver's record history. Applicant/employee acknowledges that he/she is herein informed of his/her right to request within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation requested. Such disclosure will be mailed or otherwise delivered to applicant within five days from the date of the applicant/employee's request for disclosure or such report **w**as first requested by employer, whichever is the later. Applicant/employee further authorizes the above named company to obtain an investigative consumer report through ACRAnet for employment purposes at this time or anytime during the applicant/employee's tenure with employer.

Print Full Name: _____

Former Name/Maiden Name (list all):_____

Street Address:_____

City:_____**State:**_____**Zip:**_____

Previous Address: _____

City:_____**State:**_____**Zip:**_____

***** Social Security Number:*** _____

Date of Birth:___/___/____
(In order for factual information to be obtained & reported, your date of birth and social security number are requested. This information is used solely for verification purposes in compliance with the Fair Credit Reporting Act.)

Driver's License # (if applicable)_____ **State of Issue**_____

Signature:_____***Date:*** _____

Applicant's Disclosure for Conviction Criminal History and Child or Adult Abuse Record

I understand that Walla Walla Community Hospice ("WWCH") requires a Criminal History – Child/Adult Abuse Information Act Record from the Washington State Patrol for all employees and volunteers. I consent to WWCH or its agents conducting a background check regarding me.

I make the following disclosures to WWCH in connection with such background check:

Have you ever been convicted of a crime?

____ Yes ____ No

Have findings been made against me in any civil adjudicative proceeding pertaining to child or adult abuse?

____ Yes ____ No

Have both a conviction of any crime and findings in any civil adjudicative proceeding pertaining to a child or adult abuse been made against me?

____ Yes ____ No

_____
Volunteer Name

_____ _____
Volunteer Signature Date

Walla Walla Community
HOSPICE

Request for Conviction Criminal History – Child or Adult Abuse Record

1067 Isaacs Ave
Walla Walla, WA 99362
509.525.5561 fax 509.525.3517
info@wwhospice.org www.wwhospice.org

Applicant Information			
Applicant name (Last, First, MI):			
Alias / Previous / other names, if applicable for reference checks:			
Date of Birth (Month/day/year):			
Sex/Race:			
		Yes	**No**
Since reaching age 18, have you ever been convicted of a misdemeanor or felony? *(Convictions will not necessarily bar you from employment, but are reviewed as related to the relevance of the job. Criminal history information is required upon hiring.)*			

Background checks by business, organization or insurance company

(1) A business or organization shall not make an inquiry to the Washington state patrol under RCW 43.43.832 or an equivalent inquiry to a federal law enforcement agency unless the business or organization has notified the applicant who may be offered a position as an employee or volunteer, that an inquiry may be made.
(2) A business or organization shall require each applicant to disclose to the business or organization whether the applicant:
(a) Has been convicted of a crime;
(b) Has had findings made against him or her in any civil adjudicative proceeding as defined in RCW 43.43.830; or
(c) Has both a conviction under (a) of this subsection and findings made against him or her under (b) of this subsection.
(3) The business or organization shall pay such reasonable fee for the records check as the state patrol may require under RCW 43.43.838.
(4) The business or organization shall notify the applicant of the state patrol's response within ten days after receipt by the business or organization. The employer shall provide a copy of the response to the applicant and shall notify the applicant of such availability.
(5) The business or organization shall use this record only in making the initial employment or engagement decision. Further dissemination or use of the record is prohibited, except as provided in RCW 28A.320.155. A business or organization violating this subsection is subject to a civil action for damages.
(6) An insurance company shall not require a business or organization to request background information on any employee before issuing a policy of insurance.
(7) The business and organization shall be immune from civil liability for failure to request background information on an applicant unless the failure to do so constitutes gross negligence.

**** Please also complete back side of form****

Child/adult abuse record search guidelines

1. **Searches may be conducted only on prospective employees, volunteers, adoptive parents, prospective clients, or resident.** Background checks may be conducted on prospective employees, volunteers, or adoptive parents who will be or may have unsupervised access to children less than sixteen years of age, developmentally disabled persons, or vulnerable adults. The background check is for initial employment decisions only. A prospective client's or resident's conviction record—upon the request of a business or organization that qualifies for exemption under section 501(c)(3) of the internal revenue code of 1986 (26 U.S.C. Sec. 501(c)(3) and that provides emergency shelter or transitional housing for children, persons with developmental disabilities, or vulnerable adults.

2. **Applicants must be notified an inquiry may be made.**
   A business or organization shall not make an inquiry to the Washington State Patrol unless the business or organization has notified the applicant, who may be offered a position as an employee or volunteer, that an inquiry may be made.

3. **A business or organization must prepare a disclosure statement to be signed by the applicant before a background check may be conducted. (See required disclosure items: RCW 43.43.834)**

4. **Applicants must be notified of the response.**
   The requesting agency shall notify the applicant of the Washington State Patrol's response within ten days after receipt. The employer shall provide a copy of the response to the applicant and shall notify the applicant of such availability.

Notes:

- The business or organization shall use this record only in making the initial employment or engagement decision. Further dissemination or use of the record is prohibited. A business or organization violating this subsection is subject to civil action for damages.
- Responses are limited to **Washington State records only**.
- The requested record information is furnished solely on the basis of name and/or description similarity with the subject of your inquiry. Positive identification or non-identification can only be effected upon receipt of fingerprints.
- "Business or organization" means a person, business, or organization licensed in this state, any agency of the state, or other governmental entity, that educates, trains, treats, supervises, houses, or provides recreation to developmentally disabled persons, vulnerable adults, or children under sixteen years of age, or that provides child day care, early learning, or early learning childhood education services, including but not limited to public housing authorities, school districts, and educational service districts.
- "Client" or "resident" means a child, person with developmental disabilities, or vulnerable adult applying for housing assistance from a business or organization.

I have read and understand the above **CHILD/ADULT ABUSE RECORD SEARCH GUIDELINES** pursuant to Revised Code of Washington (RCW) 43.43.830-43.43.845.

Name _____

Signature _____ Date _____

Please complete whether changed or not! ☺

CAMP AMANDA

2023 Camp Amanda Volunteer Information Form

Your Name: _____ Date: _____

Address: _____

City/State/Zip: _____

E-mail: _____ Home Phone: _____

Cell Phone: _____ May we text message you?: Yes No

Dietary Restrictions: _____

Favorite Snacks: _____

Birthday: ___/___/_____ Adult t-shirt size: XS S M L XL XXL XXXL

IN CASE OF AN EMERGENCY, PLEASE NOTIFY:

#1:
Name: _____ Relationship: _____

Address: _____

City/St/Zip: _____

Primary Phone: _____ Alternate Phone: _____

#2:
Name: _____ Relationship: _____

Address: _____

City/St/Zip: _____

Primary Phone: _____ Alternate Phone: _____

SEXUAL ABUSE PREVENTION POLICY/FORM **Policy Number: AD.S15**

NHPCO Standard(s): CES (Clinical Excellence and Safety) Standard 102, Washington State Legislature RCW 74.34.053/Oregon State Legislature ORS 418.205

Regulatory Citation(s): 42 CFR 418.52(b)(4) and 418.52(c)(6)

POLICY: Walla Walla Community Hospice prohibits and does not tolerate sexual abuse in the workplace or in any organization-related activity. Walla Walla Community Hospice provides procedures for employees, volunteers, family members, board members, patients, victims of sexual abuse, or others to report sexual abuse and disciplinary penalties for those who commit such acts. No employee, volunteer, patient or third party, no matter his or her title or position has the authority to commit or allow sexual abuse.

PROCEDURE:

Walla Walla Community Hospice has a Zero-Tolerance policy for any sexual abuse committed by an employee, volunteer, board member or third party. Upon completion of the investigation, disciplinary action up to and including termination of employment and criminal prosecution may ensue.

Sexual abuse is inappropriate sexual contact of criminal nature or interaction for gratification of the adult who is a caregiver and responsible for the patient or child's care. Sexual abuse includes sexual molestation, sexual assault, sexual exploitation, or sexual injury, but does not include sexual harassment. Any incidents of sexual abuse reasonably believed to have occurred will be reportable to appropriate law enforcement agencies and regulatory agencies.

Physical and behavioral evidence or signs that someone is being sexually abused are listed below.

Physical evidence of abuse may include but not limited to:

1. Difficulty in walking
2. Torn, stained or bloody underwear
3. Pain or itching in genital area
4. Bruises or bleeding of the external genitalia
5. Sexually transmitted diseases

Behavior signs of sexual abuse may include but not limited to:

1. Reluctance to be left alone with a particular person
2. Wearing lots of clothing especially in bed
3. Fear of touch
4. Nightmares or fear of night
5. Apprehension when sex is brought up

Reporting Procedure

If you are aware of or suspect sexual abuse taking place, you must immediately report it to the Executive Director of Walla Walla Community Hospice or any person designated by the Executive Director to receive such reports (Washington and Oregon law define hospice employees as mandatory reporters). If the suspected abuse is to an adult, you should report the abuse to your local or state Adult Protective Services (APS) Agency. If it is a child who is the victim then you should report the suspected abuse to your local or state Child Abuse Agency. If you do not know your state child abuse agency you can call the Child Help's National Abuse Hotline, 1-800-422-4453, TDD 1-800-222-4453. Appropriate family members should be notified of alleged instances of sexual abuse.

Walla Walla Community Hospice will also report the alleged sexual abuse incident to its insurance agent.

Anti-retaliation

Walla Walla Community Hospice prohibits retaliation made against any employee, volunteer, board member or patient who makes a good faith complaint of sexual abuse or who participates in any related investigation. Making false accusations of sexual abuse in bad faith can have serious consequences for those who are wrongly accused. Walla Walla Community Hospice prohibits making false and/or malicious sexual abuse allegations, as well as deliberately providing false information during an investigation. Anyone who violates this rule is subject to disciplinary action, up to and including termination.

Investigation and Follow-up

Walla Walla Community Hospice will take all allegations of sexual abuse seriously and will promptly and thoroughly investigate whether sexual abuse has taken place. Walla Walla Community Hospice may, but is not required to, use an outside third party to conduct an investigation. If Walla Walla Community Hospice has a trained internal investigator(s) in place, the investigator(s) will be used to investigate the incident. Walla Walla Community Hospice will cooperate fully with any investigation conducted by law enforcement or other regulatory agencies. It is Walla Walla Community Hospice's objective to conduct a fair and impartial investigation. Walla Walla Community Hospice provides notice to its employees, volunteers, board members and other applicable third parties that it has the option of placing the accused on a leave of absence or on a reassignment to non-patient contact.

Walla Walla Community Hospice

Acknowledgement of Sexual Abuse Policy

Acknowledgement of Receipt and Understanding of Sexual Abuse Policy

I acknowledge that I have received and read the sexual abuse policy and/or have had it explained to me. I understand that Walla Walla Community Hospice will not tolerate conduct by any employee, volunteer, board member or third party which constitutes sexual abuse. Disciplinary actions will be taken against those who are found to have committed sexual abuse.

I understand that it is my responsibility to abide by all rules contained in the Walla Walla Community Hospice Sexual Abuse Policy. I also understand how to report incidents of sexual abuse as set forth in the Sexual Abuse Policy, as well as the prohibition against retaliation toward any employee/volunteer exercising his or her rights under the Sexual Abuse Policy.

Date:_____

_____
Employee/Volunteer Signature

_____
Employee/Volunteer Printed Name

ABUSE, NEGLECT, MISTREATMENT AND EXPLOITATION **Policy Number: PC.A15**
Page 1 of 2

NHPCO Standard(s):
Regulatory Citation / Other: 42CFR 418.52(b)(4) and 418.52(c)(6)

POLICY STATEMENT: Walla Walla Community Hospice follows all Federal and State requirements regarding alleged violations involving mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source and misappropriation of patient property by anyone providing services on behalf of the hospice.

Definitions

Abuse: The intentional infliction of physical, emotional, or sexual pain or injury that results in physical harm, pain or mental anguish.
Neglect: The failure to provide necessary food, shelter, clothing, medical care or supervision.
Mistreatment: To treat someone or something roughly, wrongly or badly.
Exploitation: Intimidating or deceiving a victim in a manner that deprives him or her of money, assets or property for the benefit of someone other than the victim.

PROCEDURES:

1. During orientation, all new employees receive instruction regarding the policy and procedure, including:
    a. legal requirements for reporting suspected abuse, neglect, mistreatment and exploitation;
    b. The numbers to call as follows:
        i. WA State Dept. of Social & Health Services: 1-866-ENDHARM (1-866-363-4276)
            1. Contact Information to Report Abuse & Neglect of a child &/or Vulnerable Adult
        ii. OR Dept. of Human Services: 1-855-503-SAFE (7233)
            1. Call to report abuse or neglect of any child or adult in Oregon
    c. a review of the State's legal definitions of abuse, neglect and exploitation and mandatory reporting requirements and processes; and
    d. the requirement that staff who have reasonable cause to believe that a child, dependent adult or vulnerable adult has suffered abuse, neglect, abandonment and/or exploitation shall report the incident to the appropriate state protective authorities or the police department as required by law.
    e. The patient care coordinator is then informed of the incident and an unusual incident form is completed stating the date of report, agency to which reported, and the information reported.

2. During the admission process and throughout the course of care, hospice personnel assess the potential / likelihood of abuse, neglect, mistreatment or exploitation in the patient's environment.

3. Alleged violations of abuse, neglect, mistreatment and/or exploitation involving a hospice employee or contractor are brought to the attention of the hospice Executive Director immediately.

4. The Executive Director immediately contacts legal counsel regarding correct procedure to:
    a. immediately prevent potential further violation,
    b. investigate and document alleged violations, and
    c. determine appropriate corrective action to take in accordance with State laws, including reporting measures.

Print Name_____

Signature _____ Date _____

WALLA WALLA COMMUNITY HOSPICE

CAMP AMANDA VOLUNTEER HIPAA/CONFIDENTIALITY STATEMENT

The purpose of this confidentiality statement is to verify that you, as a WWCH Volunteer for Camp Amanda, understand that all facts pertaining to a child and /or their family members are confidential information. This information includes, but is not limited to:

Any personal information identifying the participants, such as:

- Age, gender, birthday, address, phone number, attending school, etc.,
- Grief status,
- Mental health status, and
- Social and physical behaviors.

Any information pertaining to the deceased is also confidential.

In summation, your responsibility is to understand confidentiality:

- Anything you see,
- Anything you hear,
- Anything you read,
- Anything you observe with your 5 senses,
- Anything you know about a participant and/or family member…
  MUST BE KEPT CONFIDENTIAL

Volunteers are never at liberty to discuss these conditions with other personnel, friends, or family except as it pertains to the child's care and only then with appropriate personnel (Camp Coordinator, Camp Director, Camp Mental Health Counselor, parents/guardians).

Any volunteer who violates the confidentiality of information is subject to immediate dismissal. It is the absolute responsibility of each volunteer to maintain the child/ family member's trust and the agency's integrity by maintaining confidentiality.

_____

By signing below I understand the above regarding confidentiality and agree to maintain and respect the confidentiality of Camp Amanda's camper and family information and I acknowledge the outcomes of any violations.

_____
Print Name

_____ _____
Signature Date

EXPECTATIONS FOR CAMP AMANDA STAFF & VOLUNTEERS

(A program of Walla Walla Community Hospice)

Camp Amanda, a bereavement camp for children, is committed to providing a safe and natural environment where children can heal and share their grief experience with others.

Definition: Camp Participant – a child/teen ranging from ages 7-14 participating in Camp Amanda.

All camp staff and volunteers will attend mandatory sexual abuse prevention training, in addition to Camp Amanda training. Hospice staff and volunteers will exercise good judgment to avoid behavior that could be interpreted as abuse.

1. Staff and volunteers are expected to respect that their interaction with participants is within a helping relationship and that the participants are extremely vulnerable.

2. All staff and volunteers must undergo comprehensive background checks.

3. Training in or review of the organization's sexual abuse policy with staff and volunteer sign-off is required before any staff or volunteer works at Camp Amanda or Camp Amanda Reunion.

4. Staff and volunteers are not to establish private or intimate relationships with camp participants.

5. One-on-one contact in isolation between adults and camp participants is not permitted.

6. Where one-on-one activities such as counseling must be performed in a private environment, the meeting must be in view of other adults and participants.

7. Staff and volunteers will not have contact with participants under the age of 21 years outside of Camp Amanda or Camp Amanda Reunion. Prohibited contact shall include any telephone conversations or messages, messages through social media, messages delivered through third parties, and in-person contact. Any inquiries from a participant are to be forwarded to the Camp Amanda Coordinator for appropriate action. Unexpected encounters shall be terminated as soon as reasonably possible in order to eliminate the appearance of a violation of the policy. (No-Contact Policy).

8. Staff and volunteers will respect the confidentiality of all information regarding camp participants.

9. Staff and volunteers will report any suspicion of child or sexual abuse, suicidal ideation, or threats to harm others directly to Camp Amanda Coordinator (or designee) immediately.

10. Alcohol or tobacco products will not be allowed during Camp Amanda or Camp Amanda Reunion.

11. Appropriate attire is required of staff, volunteers, and camp participants. Appropriate attire includes:
    - All clothing shall be acceptable in repair and appearance and shall be worn within the bounds of decency and good taste.
    - Clothing which display profanity, products, gangs, or slogans which promote tobacco, alcohol, drugs, sex or are in any other way distracting, are prohibited.

12. Staff and volunteers must respect the privacy of camp participants in situations such as changing clothes/showering.

13. Staff and volunteers will not disrobe or shower in the presence of *any* camp participants.

14. Sleeping arrangements for camp participants will be segregated according to gender and age categories. One-on-one sleeping arrangements between adults and youth are not permitted.

15. Staff and volunteers will accompany their camp participants throughout the camp. This includes ensuring the camp participant does not wander off at any time. (Exception: A camp participant may want to go to the bathroom facilities and will notify the staff member or volunteer.)

16. Staff and volunteers will allow the camp participants to set their own physical and emotional boundaries that provide them with the safety they need to do their grief work.

17. Staff and volunteers may be dismissed at any point in their participation in the program if the Executive Director of Walla Walla Community Hospice or designee or the Camp Amanda Coordinator deems it necessary.

Any physical contact (i.e. hugging, high five's, etc.) must be requested or initiated by the camp participants. NO EXCEPTIONS!

I acknowledge that I have read the above and foregoing expectations, have received a copy of them and agree to comply fully with them.

Print Name:_____

Signature:_____ Date:_____

CAMP AMANDA/CHILDREN'S GRIEF PROGRAM– NO CONTACT **Policy Number AD.C10**
NHPCO Standard(s):
Regulatory Citation(s): WWCH
Legislature:
L-Tag:

POLICY STATEMENT: Walla Walla Community Hospice employees, counselors, and/or volunteers who participate in any children's grief programs are forbidden from having contact with participants under the age of twenty-one (21) years outside or apart from the time that they are attending children's grief programs.

DEFINITIONS:

Children's grief programs: Camp Amanda, children's grief groups or grief workshops

Contact: The means to communicate in-person, by telephone or text messages, messages through social media such as Facebook, Instagram, Snap Chat, etc., means to communicate through software applications, messages delivered through third parties, or by letter.

PROCEDURES:

1. Walla Walla Community Hospice has zero-tolerance for any external contact.

2. Any employee, counselor, or volunteer who violates this policy shall be subject to discipline, up to and including termination.

3. If an employee, counselor or volunteer unexpectedly encounters any participant under the age of 21 outside or apart from the time that they are attending camp, groups or workshops, the employee, counselor or volunteer shall terminate such contact as soon as reasonably possible in order to eliminate the appearance of a violation of this policy.

4. Any deviations from this policy must be preapproved by the Executive Director with a written disclosure statement.

Print Name:_____

Signature:_____ Date:_____

Assumption of Risk and Liability Release Agreement

The novel coronavirus, which causes the disease COVID-19, has been declared a worldwide pandemic by the World Health Organization**. COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Walla Walla Community Hospice ("Local Camp") has put in place measures designed to reduce the spread of COVID-19. However, Local Camp **cannot guarantee** that you/you and your child(ren) will not become infected with COVID-19. Further, **attending Camp Amanda activities could increase** your risk and your child(ren)'s risk of contracting COVID-19.

By signing this Liability Release Agreement, I understand the contagious nature of COVID-19 and voluntarily assume the risk that I or my child(ren) and I may be exposed to or infected by COVID-19 by attending Camp Amanda activities, and that such exposure or infection may result in personal injury, illness, permanent disability, or death. I understand that the risk of becoming exposed to or infected by COVID-19 at Camp Amanda activities may result from the actions, omissions, or negligence of myself and/or others, including, but not limited to, Local Camp and their respective directors, officers, employees, agents, volunteers, or program participants and their families.

I voluntarily assume all of the foregoing risks and accept sole responsibility for any illness or injury to myself and my child(ren), including, but not limited to, personal injury, disability, and death, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my or my child(ren)'s attendance at or participation in Camp Amanda activities ("Claims"). On behalf of myself and my children, heirs, representatives and assigns, I hereby release, hold harmless and discharge Local Camp, and their respective directors, officers, employees, agents, and volunteers ("Released Parties") from, and covenant not to sue the Released Parties for, any Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto that I, or my children and I, may have or acquire. I understand and agree that this Liability Release Agreement includes but is not limited to any Claims based on the actions, omissions, or negligence of the Released Parties. If any provision of this Liability Release Agreement is held to be invalid or unenforceable, then that provision shall be severed, and all remaining provisions shall be given full force and effect.

Print Name of Participant: _____

Check the appropriate box: ☐ Youth Participant (Camper) ☐ Volunteer

By signing below, I acknowledge that I have read, understood, and do hereby accept the conditions of this Assumption of Risk and Liability Release Agreement.

_____

Printed Name of Parent/Guardian of Youth Participant (Camper) Date

_____

Signature of Parent/Guardian of Youth Participant (Camper) Date

_____

Signature of Volunteer/Staff Participant Date

**If no signature of volunteer/staff participant, it is assumed this release is only for youth participant above.*

COVID-19 Vaccination

Please attach copy of front and back of COVID-19 vaccination card on this page.

COVID-19 Vaccination Record Card

Please keep this record card, which includes medical information about the vaccines you have received.

Por favor, guarde esta tarjeta de registro, que incluye información médica sobre las vacunas que ha recibido.

Last Name | First Name | MI

Date of birth | Patient number *(medical record or IIS record number)*

Vaccine	Product Name/Manufacturer Lot Number	Date	Healthcare Professional or Clinic Site
1st Dose COVID-19		___/___/___ *mm dd yy*	
2nd Dose COVID-19		___/___/___ *mm dd yy*	
Other		___/___/___ *mm dd yy*	
Other		___/___/___ *mm dd yy*	

Reminder! Return for a second dose!
¡Recordatorio! ¡Regrese para la segunda dosis!

Vaccine	Date / Fecha
COVID-19 vaccine Vacuna contra el COVID-19	___/___/___ mm dd yy
Other Otra	___/___/___ mm dd yy

Bring this vaccination record to every vaccination or medical visit. Check with your health care provider to make sure you are not missing any doses of routinely recommended vaccines.

For more information about COVID-19 and COVID-19 vaccine, visit cdc.gov/coronavirus/2019-ncov/index.html.

You can report possible adverse reactions following COVID-19 vaccination to the Vaccine Adverse Event Reporting System (VAERS) at vaers.hhs.gov.

Lleve este registro de vacunación a cada cita médica o de vacunación. Consulte con su proveedor de atención médica para asegurarse de que no le falte ninguna dosis de las vacunas recomendadas.

Para obtener más información sobre el COVID-19 y la vacuna contra el COVID-19, visite espanol.cdc.gov/coronavirus/2019-ncov/index.html.

Puede notificar las posibles reacciones adversas después de la vacunación contra el COVID-19 al Sistema de Notificación de Reacciones Adversas a las Vacunas (VAERS) en vaers.hhs.gov.

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