New application

agency for persons with disabilities

*State of Florida*

# Sunland Center
# Volunteer Application

**Date**_____

**Name**_____
(Last Name) (First Name) (Middle Name)

**Mailing Address**_____
(Street or Post Office Box)

_____
City State Zip Code

**Phone**_____
Work Home Cell

**Emergency Contact Person and Telephone #**_____

**Group Name (if Applicable)**_____ **Group Chairperson**_____

**List any professional or occupation registration, license or certification you or your group hold**

**(include certificate/license)**_____

_____

**List any Special Skills, interests or hobbies:**

_____

_____

**List of three references not related to you whom you have known for more than one year:**

Name Address Telephone

_____

_____

_____

# AGENCY FOR PERSONS WITH DISABILITIES (APD)

## APD'S NOTICE OF PRIVACY POLICY & EMPLOYEE CONFIDENTIALITY AGREEMENT

This Notice of Privacy Policy & Employee Confidentiality Agreement is to ensure that each APD client's health information remains private and confidential. Each APD workforce member has an independent responsibility to protect the privacy of each client's health information. No member of the APD workforce shall permit the unauthorized access, use, or disclosure of protected health information at any time, whether the workforce member is working or not. This policy complies with the requirements set forth in the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), 45 CFR Parts 160, 162, and 164, the HITECH Act of 2009, Title XIII of the American Recovery and Reinvestment Act of 2009 ("ARRA"), Florida Statute § 501.171, as well as other applicable Florida Statutes.

HIPAA defines "protected health information" to mean individually identifiable health information that is: transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. "Individually Identifiable Health Information" means information, including demographic information collected from an individual that can be used to identify an individual—or which there is a reasonable basis to believe that information can be used to identify an individual—and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. 45 CFR §160.103. A "disclosure" means the release, transfer, provision of access to, or divulging in any manner a client's health information to an unauthorized third party. 45 CFR § 160.103. Disclosures are either authorized / permissible or unauthorized / impermissible:

(1) AUTHORIZED—An authorized disclosure of a client's health information is one that does not require a written Authorization or that does not require a client to agree or object to the disclosure prior to it being made. APD is authorized to use or disclose a client's health information for treatment, payment, and health care operations or as otherwise authorized or required by law. APD is required to follow the privacy practices described in the Notice of Privacy Practices, which is furnished to each APD client.

(2) UNAUTHORIZED—An unauthorized disclosure of a client's health information is one that is any inadvertent, unintentional, or intentional acquisition, access, use, or disclosure of protected health information by and between an authorized workforce member to an unauthorized person or entity that is not permitted by a client's written Authorization, Business Associate Agreement, Memorandum of Understanding, or as legally required to have access to such information is considered a presumed breach; it is not a breach if APD performs a risk assessment and can reasonably demonstrate that there is a low probability that the protected health information has been compromised. The test for determining a breach appears at 45 CFR §164.402(2)(i)-(iv).

Any APD workforce member who intentionally permits or discloses the unauthorized access, use, or disclosure of protected health information will be subject to disciplinary action, up to and including termination of employment, in accordance with APD Policy 6-0010, "*Confidential Information*" and the APD's Standard of Conduct. Any workforce member who knowingly violates the privacy provisions of HIPAA may also be subject to criminal penalties under federal law. 42 USC § 1320d–6.

I acknowledge that I have read and agree to the Agency's Notice of Privacy Policy & Employee Confidentiality Agreement. I further acknowledge and agree that my individual compliance with this policy is a condition of my employment with APD. I have been made aware that this signed receipt will become part of my personnel file.

_____

Print Workforce Member Name

_____ _____

Signature of Workforce Member Date