

OUR ISLAND HOME CONFIDENTIALITY and NON-DISCLOSURE AGREEMENT

Our facility's information systems and files contain confidential records pertaining to our business operations, our residents, business associates, health care professionals, and employees. Because this information is vital to the operation of the facility in providing quality care and services to our resident, it must be protected. As such, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and OIH policies governing the access, use, and disclosure of protected health or facility information, you have the responsibility to protect such data.

In your duties at OIH, you may have access to protected, confidential information such as employee and resident proprietary and health information. The purpose of this agreement is to provide you with information to assist you in understanding your obligations relative to confidential information. Remember – such information can be spoken, written or in electronic form.

YOU AGREE:

- 1) To respect the privacy and confidentiality of any information you may have access to through the course of your daily tasks, our computer system or network and that you will access or use only that information necessary to perform your job.
- 2) Not to access any information you do not need to perform the specific duties of your job/assignment.
- 3) To refrain from communicating information about a resident in a manner that would allow others to overhear such information or to discuss a resident's information with anyone not permitted access to such information in accordance with the facility's established policies or resident's wishes (e.g. friends, relatives, visitors, etc.). It is best to seek a private area to discuss the patient issues needed to complete your job. Refrain from discussing such information outside of the work setting.
- 4) To refrain from leaving such information where others who have no reason to see/ read it.
- 5) To disclose confidential resident, business, financial or employee information ONLY to those authorized to receive it. Verify that callers, visitors, etc. are allowed to receive information about residents or employees. Note: if a resident has requested that certain family members not be included in their care discussion or receive information, this must be honored.
- 6) To safeguard and not disclose your password or user ID code, if you have one, or any other authorization you may have that allows your access to protected information. You accept responsibility for all entries and actions recorded using your password and user ID code.
- 7) Not to attempt to learn or use another employee's password or user ID code to log-on to our facility's computer system or network and to immediately report to the HIPAA Compliance Officer(s) or Administrator any suspicion that your password and user ID code has been compromised.
- 8) Not to release or disclose the contents of any resident, employee or facility record except to fulfill your work assignment.
- 9) Not to remove any protected information from facility ground or copy such information except to fulfill your work assignment. (This includes work assignments, census information, etc).
- 10) Not to sell, loan, alter or destroy any protected information or reports except as properly authorized within the scope of your job assignment to do so or you have valid patient authorization to do so.
- 11) Not to leave your computer terminal or workstation unattended without *logging off*, if you have one, or using your system's screen saver function before leaving your work area or securing hardcopy information so that it may not be disclosed to unauthorized persons.

- 12) Not to access or request any protected information that is not necessary to perform your assigned job.
- 13) Not to permit others to access our facility's computer system or network using your password or ID.
- 14) To permit your access to our facility's information systems to be monitored.
- 15) Not to download or make copies of any software or application or documents without proper authorization or license.
- 16) Not to assess or download any pornography or other illegal materials or perform any illegal activity such as gambling while on the facility's computer systems or network.
- 17) Not to use our facility's computer system or network to send/forward harassing, insulting, defamatory, obscene, offending or threatening messages.
- 18) Report any suspected or known unauthorized access, use or disclosure of protected information to the HIPAA Officer(s) or Administrator. You will not be retaliated against for making such concerns known.
- 19) To abide by the HIPAA policies and procedures set forth by the facility as well as all other current OIH polices and/or regulations governing privacy issues and computer use.
- 20) To restrict personal use of the facility's computer system or network to meal and break periods and to follow the facility's established policies governing such personal use.

OIH records and computer systems (including all related equipment, software, internet, networks and devices) are provided for authorized employees or other individuals to use. OIH computer systems may be monitored by the Town of Nantucket's Information Technology department or other members for all lawful purposes, including ensuring that their use is authorized, for management of the system, to facilitate protection against unauthorized access and to verify security procedures, survivability and operational security.

All information, including personal, placed on or sent over this system may be monitored. It is property of the Town of Nantucket. Use of this OIH computer system, authorized or unauthorized, constitutes consent to monitoring of this system and information. Unauthorized use may subject you to reprimand and loss of certain related privileges. Evidence of unauthorized use collected during monitoring may be used for administration disciplinary action. A report of information collected during this monitoring process shall be available to the Town Manager as well as the OIH Administrator upon request.

You understand that the duties and obligations set forth in this document are to be adhered to at all times both at OIH, off duty, and after you are no longer a part of the OIH family due to termination of employment or services or other means. Furthermore, you understand there are both civil penalties and work penalties that may result from disregarding HIPAA requirements.

Your signature on this document indicates that the information contained herein has been explained to you, you received a copy of this document, and that you understand the rules set forth.

Name (PRINT): _____

Signature: _____

Date: _____

Check One: Employee Volunteer Other: _____

For employees: A copy of this document will be placed in the employee's personnel record.

OUR ISLAND HOME VOLUNTEER AGREEMENT

General Agreement:

To assist Our Island Home (OIH) in assessing the information provided, I hereby authorize, by signature, OIH to verify information given by me and that all information and personal references that have been provided in writing or verbally may be contacted and verified. I release OIH and any person who provides information about me from any liability or damage which may result from furnishing information requested. By signing this form, I confirm that all information I have provided is correct.

Additionally, I acknowledge I am totally responsible for my actions as a volunteer for OIH. I understand I will not receive or be entitled to any monetary compensation or employee benefits from OIH for my volunteer duties. I waive any claim, right, or cause of action arising as a result of my volunteer duties.

I agree to indemnify and defend OIH against liability or loss and against all claims or actions arising out of any damage or injury to any persons or property caused by or sustained in connection with the performance of my volunteer duties.

I understand that my voluntary participation in volunteer duties for OIH can be discontinued at any time by OIH or myself. I am fully aware of and understand the conditions of my voluntary work for OIH.

I acknowledge and agree that my volunteer work is offered freely. I confirm that I am not employed by Our Island Home.

Confidentiality:

I understand that I must keep confidential all information I gain as a volunteer at OIH and agree to abide by the following:

I will respect residents' rights to privacy and respect the confidentiality of information regarding members. I will not discuss or in any way disclose information inside or outside the program unless information is essential in connection with program business or the resident's safety.

I will respect the confidentiality of information regarding OIH operations and agree to become familiar with any and all policies, procedures, and other materials as required that discuss confidentiality and the release of information.

Signature

Date

Print Name Here

**OUR ISLAND HOME
ADULT VOLUNTEER APPLICATION (Ages 19+)**

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birth date: _____ Marital status: _____

Employer: _____

Business Address: _____

City: _____ State: _____ Zip: _____

In case of Emergency, contact: Name: _____

Phone: _____

Previous volunteer service: _____

Type of volunteer activity preferred:

- | | | |
|---------------------------|------------------------------|-------------------------------|
| _____ a) Crafts | _____ h) Fund raisers | _____ o) Bingo |
| _____ b) Social events | _____ i) Movies | _____ p) Beauty shop |
| _____ c) Spiritual events | _____ j) Room visits | _____ q) Community groups |
| _____ d) Outings | _____ k) Games | _____ r) Mail/flower delivery |
| _____ e) Exercise classes | _____ l) Art therapy | _____ s) Shopping |
| _____ f) Pet therapy | _____ m) Music therapy | _____ t) Other: _____ |
| _____ g) Bookmobile | _____ n) Reminiscence groups | |

Special education or training which you feel is relevant to working with nursing home patients:

Community group affiliations (Clubs, Councils, Committees, Church, etc.): _____

Days and Hours desired: _____

Signature of Applicant: _____ Date: _____



OUR ISLAND HOME

9 East Creek Road, Nantucket, Massachusetts 02554
(508) 228-0462 FAX (508) 228-6875

OIH BACKGROUND CHECKS FORM

APPLICANT/EMPLOYEE INFORMATION (PLEASE PRINT)

LAST NAME FIRST NAME MIDDLE NAME

MAIDEN NAME OR ALIAS (If Applicable) PLACE OF BIRTH

DATE OF BIRTH SOCIAL SECURITY NUMBER

Previous Addresses/ State lived in: _____

----- OIH OFFICE USE ONLY -----

Print out all verifications done and attach them to this form

CORI Requested On-Line: _____
DATE Received/Filed Check Performed by (HR, or CORI authorized indiv)

CNA Registry:
State: _____
DATE Received/Filed SIGNATURE

State: _____
DATE Received/Filed SIGNATURE

State: _____
DATE Received/Filed SIGNATURE

State: _____
DATE Received/Filed SIGNATURE

Sex Offender Registry: _____
DATE SIGNATURE

HHS-OIG Exclusion List: _____
DATE SIGNATURE