Children's Bereavement

VOLUNTEER LIABILITY RELEASE/MEDICAL TREATMENT CONSENT FORM
2021

In consideration of (your name) _____ choosing to participate in Children's Bereavement events/activities, I understand that there exists a risk of personal injury during such an event, I hereby allow myself to participate in Children's Bereavement activities and release Peace Hospice of MT /Benefis Health System, its agents officers, employees, and volunteers from any and all liability claims, demands, actions and causes of actions arising out of or related to any claim, injury, damage, including death that may be received by myself by reason of my participation in the above event. Furthermore, the under signed expressly agrees to indemnify and hold harmless Peace Hospice of Montana/Benefis Health System, its agents, officers and servants against loss from any and all further claims and actions that may hereafter at any time be brought by myself for the purpose of enforcing a claim for damage on account of injuries sustained by reason of the event. In case of serious injury or illness, I give medical authorities permission to treat me as needed.

This release shall be binding upon the heirs and personal representatives of the undersigned.

Dated the _____ day of _____ 2021

Signature: Volunteer_____

Children's Bereavement

VOLUNTEER PHOTO/MEDIA CONSENT FORM 2021

During Children's Bereavement Program activities, photos or other media forms may be taken and may be used within educational presentations, training tools, promotions, in printed text or materials by Peace Hospice Children's Bereavement Program and Benefis Health System. Photos may also be taken home with program participants.

I, _____, (name) want to participate in all of the above and give permission to use any photo, media, or video with me, my name or other means that could identify me.

Volunteer Signature:_____

Date:_____

THANK YOU!

Peace Hospice Children's Bereavement Volunteer Contract

Name: _____

1. I have read my job description and will fulfill that role to the best of my ability.

2. I understand that I am part of a team. Our purpose in working together is to make the Children's Bereavement Program beneficial for all, therefore, I agree to be flexible.

3. I understand my role as a part of this team, and will report to the Camp Francis Director, Teen Retreat Director, or the Children's Bereavement Coordinator if any situations arise that need a resolution.

4. I understand the rules prohibiting controlled substances.

5. I have been given a form on confidentiality and agree to its terms. I also agree to report to the Camp Francis Director, Teen Retreat Director, or Children's Bereavement Coordinator if concerns or suspicions of abuse or confidentiality arise.

6. I understand that the Camp Francis Director, Teen Retreat Director, or Children's Bereavement Coordinator have the discretion to dismiss me from a program on the suspicion of violation of program rules.

7. I agree that if anytime after accepting this assignment that I learn that I cannot fulfill this contract, I will immediately let the Camp Francis Director, Teen Retreat Director, or Children's Bereavement Coordinator know so that the assignment can be given to another Children's Bereavement Volunteer.

8. I agree to remain in the camp site, retreat site, or other program site until my assigned clean-up job is done and the debriefing is complete.

9. Volunteers are the heart and soul of the Children's Bereavement program, without you, we could not do what we need to do for a successful program!

10. You are not expected to be a grief facilitator, but to be a friend, listener and comforter to children, teens, and their families. This is an important piece of children's and teen's grief.

Signature: _____ Date: _____

CONFIDENTIALITY STATEMENT

Camp Francis, the Darcy's Hope Retreat, and other programs of Peace Hospice Children's Bereavement touch human life intimately in many ways. We as staff will frequently be observers and recipients of confidential information concerning participants and their families. It may be a fact, series of facts or a situation in the participant's life that is heard or observed with the implicit understanding that this information be preserved as a sacred trust.

Confidentiality is the preservation of information concerning participants and staff which is disclosed. Confidentiality is based upon the basic right of privacy of participants: it is the ethical obligation of the staff member and is necessary to create effective trust.

As the participant's information is shared, the obligation binds all equally. The participant's right, however, is not absolute: the following are exceptional cases when confidentiality may not be the priority:

- When there is a suicidal expression
- Physical, mental, sexual abuse and/or neglect
- Reason to be concerned about drug/alcohol use by a child or teen (We reserve the right to inform the parent/guardian)
- Court orders
- When we learn a participant may commit an act of violence.

If you have concerns or suspicions of abuse or other confidentiality issues please inform the Camp Francis Director, Teen Retreat Director, or Children's Bereavement Coordinator immediately.

By signing this form, I indicate that I have read and understand to adhere to the confidentiality statement.

_____ _____

Name Date

Exhibit B

Benefis
HEALTH SYSTEM

Benefis Health System – Information Systems Privacy/Security Agreement

Welcome to Benefis Health System's (BHS) Information System. We hope you will take advantage of every educational opportunity to familiarize yourself with the system and enjoy the advantages and efficiencies it provides.

Depending upon your system rights, you may have access to confidential patient information and/or confidential proprietary business information. Benefis Health System has in place policies and procedures to ensure patient and business information is held in strict confidence.

A patient's right to privacy means safeguarding the content of information including, but not limited to, patient paper records, verbal, video, audio, and/or computer stored information from unauthorized use and disclosure. Access to protected health information is limited to individuals designated by law, regulation, policy, or duly authorized as having a "need to know".

Unauthorized access or dissemination of patient information is a serious violation of legal and ethical obligations. Montana and Federal statutes protect patient health information, making it a criminal offense and/or subjecting anyone improperly releasing patient information to civil penalties and fines. Intentional breach in confidentiality may be considered gross misconduct, which is cause for loss of system privileges and disciplinary action up to and including termination.

By signing this agreement you agree to the following:

1. I will safeguard my computer password. I will not log on to any Benefis Health System computer that currently exists or may exist in the future, using a password other than my own. I will not allow anyone to use my password to log on to any Benefis Health System computer system. I will log off the Benefis Health System computer system as soon as I have finished using it.
2. I will treat all information received during my association with Benefis Health System, which relates to patients, as confidential and privileged information.
3. I will not access patient information unless I have a 'need to know' this information in order to provide effective and responsive service to our patients.
4. I am not permitted to access my own medical record or another individual's health information because of personal request, personal curiosity or personal reasons.
5. I will not disclose patient information to any person or entity, other than as necessary to perform my job or as necessary to provide effective and responsive service to our patients.
6. I will not take patient information from the premises of Benefis Health System in paper or electronic form unless authorized to do so. I will not reveal any Benefis Health System information to any third-party without authorization.
7. I will not transmit electronically or otherwise Benefis Health System documents or information related to Benefis' systems, sensitive information or patient information unless authorized and will use approved encryption/authentication software.
8. I will not load or download information or programs onto Benefis Health System computer systems without approval from the Information Technology Services Department.

I have read and understand the above statements.

Signature	Title	Date
		/ /
Full Name (Please Print)	**Department/Office**	**Initials**

Fax to: 406-455-4747. Please allow seven days for processing. For questions, call 406-455-5711

Rev: 10/18

HOSPICE VOLUNTEER PROGRAM

Benefis HEALTH SYSTEM

BACK TO SARA GRAFT
Thank you!

BENEFIS HEALTH SYSTEM BACKGROUND RELEASE AND AUTHORIZATION FORM

PLEASE PRINT:

First Name _____ Middle Initial _____

Last Name _____ Date of Birth (MMDDYYYY) _____

Social Security Number _____ Primary Telephone Number _____

Current Address _____ Apartment # _____ #yrs at this address _____

City _____ State _____ Zip Code _____

Driver's License Number (no dashes) _____ License State _____

Email Address _____

Benefis performs a background check on all successful applicants. In order to perform the check we need your driver's license number and date of birth. This information is never disclosed to interviewers and is only available to the employment office once you have been selected for a position. If you should have any concerns or questions, please call Benefis Employment at 406.455.5175.

Date: _____ Signature of Applicant: _____

Print Name: _____

NAME_____

DATE_____

Peace Hospice of Montana
Children's Bereavement Program
Email: kevinsukut@benefis.org
1101 26th Street South (mailing address)
Great Falls, Montana 59405
(406) 455-3065

PEACE HOSPICE CHILDREN'S PROGRAM

Children's Bereavement Volunteer Competency Questions

As a department of Benefis Health System, in order to help ensure our accreditation, Peace Hospice requires annual volunteer competency testing. Please respond to the following questions as concisely and legibly as possible and return your responses. Thank you for your dedication, hard work, flexibility, and teamwork!

Mark each answer with a true or false.

1. Children often have no need for grief support because they are too young to fully understand the grieving process anyway. _____

2. Adults often try to protect children from loss, but many times the child knows more than adult's think. _____

3. Guilt, Anger, Relief, Blame, and Denial are all common feelings of a grieving child. _____

4. There are many different types of loss that can affect children. _____

Mark the best answer for the following questions.

5. Children may demonstrate sadness by
   a. Withdrawing ☐
   b. Crying ☐
   c. Seeming perfectly content ☐
   d. All of the above ☐

6. Which is an example of Companioning?
   a. Telling the child what grief is ☐
   b. Comparing your own story of loss ☐
   c. Being present with someone as they experience grief ☐

Write each answer.

7. If a child is hesitant to talk about the person who died it is a good idea to try to convince them to do it.

8-10. Name three out of the five stages of grief.