Our Children's Homestead *and*

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a division of Our Children's Homestead

CONFIDENTIALITY and SECURITY AGREEMENT

Non-employee Form

(Associate Staff, Foster Parents, Interns, Volunteers, Temporary Employees, etc...)

As an associate staff member, foster parent, volunteer, service provider, or temporary employee of Our Children's Homestead, hereafter OCH, you may have access to confidential information including client, financial or business information obtained through your association with OCH. The purpose of this Agreement is to help you understand your personal obligation regarding confidential information. (See Information Services Information Protection Policy.) Confidential information is valuable and sensitive and is protected by law and by strict OCH policies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires protection of confidential information contained within our information system. Inappropriate disclosure of client data may result in the imposition of fines up to $250,000 and ten years imprisonment per incident.
Accordingly, as a condition of and in consideration of my access to confidential information, I promise the following:

1. I will not access confidential information for which I have no legitimate need to know and for which I am not an authorized user.

2. I will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information unless expressly permitted by existing policy except as properly approved in writing by an authorized officer of OCH within the scope of my association with OCH

3. I will not utilize another user's password in order to access any system. I will not reveal my computer access code to anyone else unless a confirmed request for access to my password has been made by Information Services and I am able to confirm the legitimacy of the request and the requestors. **I accept personal responsibility for all activities occurring under my password.**

4. If I observe or have knowledge of unauthorized access or divulgence of confidential information I will report it immediately to my supervisor or to the Chief Security Officer.

5. I will not seek personal benefit or permit others to benefit personally by any confidential information that I may have access to or that I access as an unauthorized user.

6. I will respect the ownership of proprietary software and not operate any non-licensed software on any computer.

7. I understand that all information, regardless of the media on which its stored (paper, computer, videos, recorders, etc.), the system which processes it (computers, voice mail, telephone systems, faxes, etc.), or the methods by which its moved (electronic mail, face to face conversation, facsimiles, etc.) is the property of OCH and shall not be used inappropriately or for personal gain. I also understand that all electronic communication shall be monitored and subject to internal and external audit.

8. I agree to abide by all OCH rules and regulations as specified in OCH Policies unless specifically altered by a separate contractual agreement.

9. I understand that my failure to comply with this Agreement may result in disciplinary action, which might include, but is not limited to, termination of employment and/or loss of my privileges within OCH.

By signing this agreement, I acknowledge that Our Children's Homestead has an active on-going program to review records and transactions for inappropriate access and I understand that inappropriate access or disclosure of information can result in penalties up to and including termination of employment and/or legal action.

_____ _____

Signature Date

_____

Printed Name

Rod R. Blagojevich
Governor

Erwin McEwen
Acting Director

Illinois Department of Children & Family Services

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

I, _____, understand that when I am employed as a
(Employee Name)

_____, I will become a mandated reporter under the
(Type of Employment)
Abused and Neglected Child Reporting Act [325 ILCS 5/4]. This means that I am required to report or cause a report to be made to the child abuse Hotline number (1-800-25A-BUSE) whenever I have reasonable cause to believe that a child known to me in my professional or official capacity may be abused or neglected. I understand that there is no charge when calling the Hotline number and that the Hotline operates 24-hours per day, 7 days per week, 365 days per year.

I further understand that the privileged quality of communication between me and my patient or client is not grounds for failure to report suspected child abuse or neglect, I know that if I willfully fail to report suspected child abuse or neglect, I may be found guilty of a Class A misdemeanor. This does not apply to physicians who will be referred to the Illinois State Medical Disciplinary Board for action.

I also understand that if I am subject to licensing under the Illinois Nursing Act of 1987, the Medical Practice Act of 1987, the Illinois Dental Practice Act, the School Code, the Acupuncture Practice Act, the Illinois Optometric Practice Act of 1987, the Illinois Physical Therapy Act, the Physician Assistants Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Athletic Trainers Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Act, the Naprapathic Practice Act, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, I may be subject to license suspension or revocation if I willfully fail to report suspected child abuse or neglect.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me under the Abused and Neglected Child Reporting Act.

_____
Signature of Applicant/Employee

_____
Date

CANTS 22
Rev. 11/2006

Office of the Director
406 E. Monroe Street • Springfield, Illinois 62701

OUR CHILDREN'S HOMESTEAD
FINANCE DEPARTMENT
PAYMENT AUTHORIZATION FORM

NAME_____

CONTRACT DATE_____

ADDRESS
STREET _____

CITY _____

STATE _____ZIP_____

I authorize Our Children's Homestead to deposit my payment check into my account (CHECKING only). I have attached a voided check for reference. I will notify the Finance Department of any changes to my account.

ATTACH
VOIDED
CHECK
HERE