Heart of the Rockies Regional Medical Center Auxiliary

Thank you for your interest in becoming an Auxiliary volunteer. Following are the steps to become a volunteer. Once your application form is received we will contact you with next steps and specific dates for training.

1. Return the completed application form and confidentiality agreement to the Gift Shop or to Karen Moore, Auxiliary Liaison at karen.moore@hrrmc.net or call 719.530.8221.
2. Application, $25 annual dues and Confidentiality Form.
3. Once we have your application, you will receive an email link for a Background Check. The link will expire after 24 hours. Once completed the process takes 3-4 days to clear.
4. Attend HIPAA Training (2nd Tuesday of each month) from 11:30 am – 12:30 pm in the second floor conference rooms. Confirm your attendance prior to the class with Karen Moore.
5. Submit proof of Flu Shot (only during flu season) and COVID vaccination to Karen.
6. Schedule a TB Skin Test by calling Tracy McConathy 719.530.2294.
7. Once all of the above requirements are confirmed we will schedule you to have your photo taken for your badge.
8. Issuing your badge is the last step to becoming an HRRMC Auxilian! Please coordinate receipt of your badge with Human Resources in 2nd floor Admin Office. Your badge is required to volunteer in any areas of the hospital or clinic.

Thank you!

HEART OF THE ROCKIES REGIONAL MEDICAL CENTER
AUXILIARY APPLICATION

NAME_____ DOB_____

MAILING ADDRESS_____

TELEPHONE NUMBER_____CELL PHONE_____

EMAIL ADDRESS: _____

HAVE YOU EVER BEEN A MEMBER OF A HOSPITAL AUXILIARY? ____IF SO, WHERE_____

WHAT IS YOUR REASON FOR WANTING TO JOIN THE AUXILIARY? _____

IN WHAT AREA OF THE HOSPTIAL WOULD YOU LIKE TO WORK? (Circle all that apply)

Gift Shop In-patient rehabilitation/swing bed Physical Therapy

VOLUNTEER PLEDGE

Believing that the hospital has real need of my services as a volunteer:

I will be punctual and conscientious in the fulfillment of my duties and accept supervision graciously.

I will conduct myself with dignity, courtesy and consideration.

I will consider as confidential all information which I may hear directly or indirectly concerning a patient, doctor or any member of personnel and will not seek information in regard to a patient.

I will take any problems, criticisms or suggestions to the Director of Volunteers.

I will endeavor to make my work of the highest quality.

I will uphold the traditions and standards of this hospital and will interpret them to the community at large.

_____ _____
Applicant Signature/Date Director of Volunteers/Date

Active Membership $10.00 _____ Associate Membership $20.00 _____

HEART OF THE ROCKIES
REGIONAL MEDICAL CENTER

P.O. Box 429
1000 Rush Drive
Salida, CO 81201
719.530.2200

CONFIDENTIALITY AGREEMENT
WORKFORCE

Applies to all Heart of the Rockies Regional Medical Center (HRRMC) workforce members including: employees; health care professionals; volunteers; agency and temporary personnel; and students and residents (regardless of whether they are HRRMC trainees or rotating through HRRMC facilities from another institution).

It is the responsibility of all HRRMC workforce members to maintain the privacy, security and confidentiality of patient, employee, financial and business information. As persons authorized to access, or who may become privy to, confidential electronic, written, and oral information, workforce members are required to comply with applicable laws and regulations, including but not limited to HIPAA and HRRMC policies and procedures governing confidential information.

Confidential Protected Health Information (PHI) includes but is not limited to the following:

1. Any individually identifiable health information that is created or received by a health care provider that relates to (i) the physical or mental health or condition of an individual, (ii) the provision of health care to an individual, or (iii) the payment for health care provided to an individual, whether such information is in paper, electronic, or verbal form;
2. Medical information concerning the patient's history of illness, mental or physical condition, diagnosis, treatment, prognosis, test results, verbal conversations, research records, and financial information, etc., as well as the patient's family members' health and financial information;
3. Insurance, financial, and billing information regarding the patient or patient's representatives;
4. Information acquired about a patient or patient's family as a result of their seeking health care or services from HRRMC;
5. Visual observation of patients receiving medical care or accessing services from HRRMC; and
6. Verbal information provided by or about a patient.

Confidential Employee and Business Information includes but is not limited to the following:

1. An employee's home telephone number and address, spouse's or other relatives' names, Social Security Numbers, or income tax withholding records;
2. Information related to evaluation of employee performance, disciplinary action, or personnel file information;
3. Peer review, risk management and quality improvement activities, and information protected from disclosure by law or under the attorney-client privilege;
4. Other such information obtained from HRRMC records which, if disclosed, could constitute an unauthorized invasion of privacy; and
5. Disclosure of confidential business information, such as trade secrets or other proprietary information that would cause harm to HRRMC.

I agree to maintain and protect the privacy, security and confidentiality of the above forms of information. I will use and disclose confidential information only (i) as necessary for me to perform my legitimate duties as defined by my employment, contract, or other affiliate relationship with HRRMC, and (ii) when authorized by law and HRRMC policy. I specifically understand and agree to the following:

1. **EDUCATION AND TRAINING:** I acknowledge that I receive periodic education and training from HRRMC regarding laws, regulations, and HRRMC policies and procedures governing access, use, and disclosure of confidential information, and I agree to comply with such legal, regulatory, and policy requirements at all times.
2. **LOCATION OF POLICIES:** I have been informed that HRRMC policies and procedures pertaining to confidential information can be found via the link on the HRRMC intranet.
3. **SECRECY OF UNIQUE IDENTIFYERS, USERNAMES AND PASSWORDS:**
   a. I will safeguard and will not disclose to any other person my usernames and passwords or any other authorization codes that allows me access to confidential information. I agree to maintain the secrecy of all usernames and passwords issued and created by me. I understand that my usernames and passwords are unique to me and constitute my signature and authority to use HRRMC information technology systems, and that any activity on such systems accessed using my usernames and passwords will be attributable to me unless or until I notify HRRMC that my usernames and passwords may have been compromised. I will not disclose my usernames and passwords to anyone.
   b. I will be responsible for misuses or wrongful disclosure of confidential information resulting from my unauthorized sharing of my access codes with another person and/or for failure to appropriately safeguard my access to confidential information.
   c. I will log off HRRMC computer systems after use and when I am away from my workstation.
   d. I will not log on to a system or access confidential information to allow another person access to that information or to use that system.

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e. I will report any suspicion or knowledge that my access code, authorization, or any confidential information has been misused or disclosed without proper authorization.

4. **SAFEGUARDING CONFIDENTIAL INFORMATION:**
   a. I will access, use and disclose confidential information only as needed by me to perform my legitimate duties as defined by my role and job description.
   b. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other confidential information generated in connection with individual patient care, risk management, and/or peer review activities.
   c. I will not access, use, or disclose confidential information which I have no legitimate need to know.
   d. I will not in any way photograph, store, transmit, disclose, copy, release, alter, revise, or destroy any confidential information except as authorized by law and HRRMC policy and within the scope of my HRRMC role and job description.
   e. I will not misuse or carelessly handle confidential information. I will not download or transfer computer files containing confidential information to any non-HRRMC computer, data storage device, portable device, telephone, or other device capable of storing digitized data.
   f. I understand that it is my responsibility to ensure that confidential information in my possession is maintained in a physically secure environment, and is transported in a secure manner.
   g. I will only print documents containing confidential information in a physically secure environment, will not allow other persons' access to printed confidential information, will store all printed confidential information in a physically secure environment, and will destroy all printed confidential information when my legitimate need for that information ends, in a manner that protects the confidentiality of the information.
   h. I will not access, view, copy, photograph, record or share with others, verbally or in other form, any confidential information of a family member, coworker, friend, neighbor, public figure or others without proper authorization.
5. **ACCESS TO MY OWN HEALTH AND BILLING INFORMATION:** Accessing my own health and billing information via paper or the electronic health record and other systems without proper authorization from HRRMC is prohibited. I understand that if I want to view or receive copies of my medical record I must go to the Medical Records Department and complete an "Authorization for Disclosure of Health Information" form. The department representative will retrieve the records for me. I am aware that I have the option to access certain of my health information via the online Patient Portal. I understand that if I want access to my billing information I must contact the Patient Financial Services Department and follow the established protocol for obtaining such information.
6. **SECURITY OF CONFIDENTIAL INFORMATION:** I will keep all confidential information secure from being seen, accessed or shared with others who are not authorized to have the information.
7. **EMAIL, INTERNET, CELL PHONE, SECURE TEXTING, AND CAMERA USE:** My usage of the HRRMC email system, internet, cell phone, secure texting, and camera use will comply with the policies of HRRMC, and with all applicable laws and regulations, including but not limited to HIPAA or copyright law. Use of any social media venues, such as but not limited to: Facebook, Instagram, Twitter, Linked-In, and cell phones, pictures/video, audio or public blogs are prohibited for posting or communicating confidential HRRMC information.
8. **OWNERSHIP OF INFORMATION:** I agree that any information, confidential or not, created by or received through me at my work or training, is and shall remain the property of HRRMC. I understand that patient medical records and business financial information are the property of HRRMC.
9. **REPORT OF KNOWN AND SUSPECT PRIVACY VIOLATIONS:** I will report known and suspected violations of these requirements to the HRRMC Compliance Hotline and to the Privacy Officer.
10. **AUDITING:** I understand that HRRMC performs routine audits and reviews patient records and other information systems in order to identify inappropriate and unauthorized access, use and disclosure of confidentiality information.
11. **DISCIPLINE AND LIABILITY:** I understand that in the event of a breach or threatened breach of this Confidentiality Agreement and/or HRRMC policies, I may be subject to disciplinary action up to and including termination from my employment, contractual or other affiliation relationship with HRRMC, in addition to legal and/or financial liability.

Acknowledgement to be reviewed and signed upon employment, contractual or other engagement and annually thereafter:

I certify by my signature that I have read, understand and agree to the terms and conditions of this Confidentiality Agreement. I understand that my obligation to safeguard patient confidentiality and other confidential HRRMC information continues after I am no longer a HRRMC workforce member.

Workforce Member Printed Name Signature Date Signed

COLORADO
Department of Public Health & Environment

Colorado Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **adults** for latent TB infection (LTBI) testing. **Call the Colorado Tuberculosis Program to report a suspected case of TB at 303-692-2656, and for general questions, call 303-692-2638. Please Note: A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.**

Check appropriate risk factor boxes below.

LTBI testing is recommended if any of the 4 boxes below are checked.

If LTBI test result is positive and active TB disease is ruled out, LTBI treatment is recommended.

Birth or foreign travel of ≥ 1 month consecutively in a country/countries with an elevated TB rate.

- Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for foreign-born persons.
- **Note**: Doctors may make individual decisions based on the information supplied by the individual during the evaluation. Individuals who have traveled to TB-endemic countries for the purpose of medical or health tourism for less than one month may be considered for further screening based on the risk estimated during the evaluation.

☐ Yes
☐ No

Medical conditions increasing risk for progression to TB disease

Radiographic evidence of prior healed TB, low body weight (10% below ideal), silicosis, diabetes mellitus, chronic renal failure or on hemodialysis, gastrectomy, jejunoileal bypass, solid organ transplant, head and neck cancer.

☐ Yes
☐ No

Immunosuppression, current or planned

HIV infection, injection drug use, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication.

☐ Yes
☐ No

Close contact to someone with infectious TB disease at any time

☐ Yes
☐ No

Patient name: _____ Provider: _____

Date of birth: _____ Assessment date: _____

(Place sticker here, if applicable)

See the Colorado Tuberculosis Risk Assessment User Guide for more information about using this tool.
Adapted from the California Tuberculosis Risk Assessment available on the PROVIDERS page at www.ctca.org.