



**MENTAL HEALTH ASSOCIATION
OF SOUTH CENTRAL KANSAS**

555 North Woodlawn, Suite 3105
Wichita, KS 67208
(316) 685-1821/Fax (316) 685-0768
e-mail: compeer@mhasck.org



COMPEER VOLUNTEER APPLICATION

Name _____ Date _____

-

Address _____ Home _____

Phone _____

City _____ Zip _____ Work _____

Phone _____

I am at least 18 years of age Yes No Foreign Languages Spoken _____

Best time and place to call _____ Email _____

Address _____

Highest Educational Level _____ Last year of

Attendance _____

Employment of Last 5 years:

| Employer | Job Title | Dates on this Job: |
|----------|-----------|--------------------|
|----------|-----------|--------------------|

Volunteer Experience:

| Agency or Program (Location) | Service provided | Dates of Service |
|------------------------------|------------------|------------------|
|------------------------------|------------------|------------------|

-

Do you have the use of a car? _____ We will need a copy of your driver's license and proof of insurance.

How did you hear about COMPEER? _____

—

Who at your work may we contact as a reference? _____

Phone _____ Address: _____

—

(Rev. 01/02)

References:

Please list two references who are **not relatives** and have known you for at least one year. Please print clearly.

1) Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

—

What is your relationship to this person?

2) Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

—

What is your relationship to this person?

Please list one **family member** with whom you have had contact with in the past year.

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

—

What is your relationship to this family member? _____

The Mental Health Association is a not for profit, 501(c)3 organization. Our mission is to promote mental health, prevent mental disorders and achieve victory over mental illness through advocacy, education, research and service to people of South Central Kansas. As a volunteer, I support the mission and philosophy of the Mental Health Association.

EMERGENCY NOTIFICATION:

In an emergency notify:

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Phone _____

Signature _____

Date _____



Coordinator Initials _____

Program _____

Submitted Date _____

KBI / MVR RELEASE OF INFORMATION

ID CODE: **902KS3547**

I, _____, give permission for the release of any information concerning myself in the records of Kansas Bureau of Investigation, Motor Vehicle Reports, Kansas Sex Offender Registry and references provided on the application to:

Compeer Program
Mental Health Association of South Central Kansas, Inc.
555 N. Woodlawn, Suite 3105
Wichita, KS 67208

I understand that all such information so released will be for the exclusive and confidential use of this organization.

Signature _____ Date _____

Please Print

Full Name _____
(Last) (First) (Middle)

Address _____

Kansas Department of Social and Rehabilitation Services
Child Abuse and Neglect Central Registry
PO Box 2637
Topeka, KS 66601

Child Abuse and Neglect Central Registry
Release of Information

Date
of

Birth _____

“Also Known As” or Maiden Name _____

Other Names (incl. “Nicknames”----John/Jack) _____

Social Security Number _____ Race _____

Sex _____ Kansas Drivers License Number _____

For Internal Use Only

Phase 1 Approved Yes No Date _____
(KBI, MVR, Sex Offender Registry)

Phase 2 Approved Yes No Date _____
(SRS Adult/Child Abuse Registry)

I, _____, give permission for the release of any information concerning
(Please print complete first, middle and last name)

Myself in the Child Abuse and Neglect Central Registry to:

Contact Person: Patty Gnefkow

Agency Name: Mental Health Association of South Central Kansas

Mailing address: 555 N. Woodlawn, Ste. 3105

Wichita, KS 67208

Phone Number: (316) 685-1821

I understand that all information released will be for the exclusive and confidential use of the above
named organization/person/agency.

☆☆ **Please complete the information below by printing in ink. Please print legibly. Do not leave
any space blank. All requested information is required to process this request. Incomplete
information will result in the release not being processed and will be returned as insufficient.** ☆☆

First, Middle and Last Name: _____

Maiden Name: (Female applicant only) _____

Married Names, Nicknames or Other Names Used:

(Use N/A if no other names used.) _____

Date of Birth: _____ Race: _____

Social Security # _____ Gender: Male Female

Signature: _____ Date: _____

Current Address: _____

Each request must be submitted with payment prior to the request being processed. Please attach appropriate fee of \$10.00 per release of information. **The agency submitting this form is responsible for the fee.** All releases and fees should be sent via postal mail to the attention of SRS, Child Abuse and Neglect Central Registry, P.O. Box 2637, Topeka, KS 66601. The following state agencies are exempt from the \$10.00 fee: JJA, KNI, Dept. Of Education-Central Office, KDHE, State Hospitals, State Correctional Institutions, Attorney General's Office, Kansas School for the Blind, Kansas School for the Deaf, Child Welfare agencies in other states. Mentor record checks, i.e. Big Brothers Big Sisters, are exempt from the \$10.00 fee. For a complete list of Mentor Programs, go to: <http://www.ksmentors.ks.gov/recordscheck.htm>. If this is a mentor record check, please make sure the box below is checked.

Mentor Program: If yes, please check

For Central Registry Use Only

___ **FEE ATTACHED**

RELEASE OF INFORMATION

PLEASE **PRINT** THE FOLLOWING INFORMATION – Use "NA" if not applicable

I, _____, give permission for the release of any information concerning myself in the Social and Rehabilitation Services Adult Abuse, Neglect and Exploitation Central Registry to:

Patty Gnefkow, Director
Compeer® Programs
Mental Health Association of South Central Kansas
555 N. Woodlawn, Suite 3105
Wichita, KS 67208

I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and the information provided is true and correct to the best of my knowledge.

Maiden Name and/or Other Names known by (**Print ONLY**): _____

Any Other Married Name(s): _____

DOB (**mm/dd/yyyy**): _____ SS#: _____

Nationality: _____ Sex: _____

Signature: _____ Date: _____

Address: _____

City, State, Zip: _____

For the Adult Abuse, Neglect and Exploitation Central Registry use only:

Information contained in the APS Central Registry:

No Record () _____ Yes () _____

Perpetrator's Name: _____

County Reporting: _____

Date Report Received: _____

Case Finding: _____

Initial: _____ Date: _____