VARSA
VASHON ALLIANCE TO REDUCE SUBSTANCE ABUSE

Coalition Involvement Agreement

This Coalition Involvement Agreement (CIA) is Vashon Alliance to Reduce Substance Abuse (VARSA)

and _____ shall be from: ____/____/____

[Member's Name] *[Start Date]*

☐ General Membership : _____

[Sector]

☐ Primary Sector Leadership: _____ ☐ Interim ☐ Full Term

[Sector]

Full Name: _____

Organization: _____

Address: _____

Preferred Phone: _____

Preferred Email*: _____

The best way to reach me is: ☐ Email ☐Voice message ☐Text ☐Other _____

Are you under age 21? ☐ Yes ☐No

1. VARSA will be held responsible to:
   - 1.1. Create and follow By-laws, Code of Conduct, Confidentiality and Ethics, and Policies & Procedures.
   - 1.2. Formulate coalition goals and objectives.
   - 1.3. Oversee operations of activities, programs, and paid staff.
   - 1.4. Continue to seek new membership of the coalition.
   - 1.5. Create and follow a strategic action plan.
   - 1.6. Create a credible and relevant sustainability plan that includes volunteer membership and resources, both financial and material.
   - 1.7. Respect the rights of VARSA members to hold their own opinions and beliefs.

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2. _____ will be held accountable for:

[Member's Name]

2.1. Supporting the coalition's mission and vision.
2.2. Adhering to VARSA By-laws, Code of Conduct, Confidentiality and Ethics, and Policies & Procedures.
2.3. Acting as a positive role model for youth, families, and peers.
2.4. Attending monthly full coalition meetings.
2.5. Participating in at least one subcommittee.
2.6. Attending coalition sponsored programs, town hall meetings, and community events.
2.7. Participating in sustaining the coalition's capacity, involvement, and energy.

3. Please review the following to help us make the most effective use of your unique background, interests and abilities.

3.1 Which of the following best describes your primary place of employment or affiliation: *(Choose only ONE)*

☐ Business Community	☐ Higher Education	☐ Municipality
☐ Civic/Volunteer Org.	☐ Latino Community	☐ Parent
☐ Community Task Force	☐ Law Enforcement	☐ Public Health
☐ Elders	☐ LGBTQ Community	☐ Recreation Department
☐ Faith/Religious Org.	☐ Media	☐ Youth (under 21)
☐ Health Care Professional	☐ Middle/High School Staff	☐ Youth Services
☐ Other:		

3.2 Indicate resources/services that you or your organization can provide for VARSA: *(Check ALL that apply)*

☐ Advertising for VARSA events
☐ Design, social media and web services
☐ Educational presentations for VARSA and community members
☐ Hosting or sponsoring a VARSA meeting or event at your facility
☐ Printing or photocopying of VARSA materials
☐ Professional training for VARSA and community members
☐ Providing volunteers to assist with VARSA events
☐ Other:

3.3 Which actions will you take to help reduce underage drug and alcohol use? *(Check ALL that apply)*

☐ Distribute informational materials to parents and other adults

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☐ Assist with data collection: ☐youth surveys ☐adult/parent surveys ☐focus groups,
☐ Encourage local grocery stores/restaurants/bars to carefully check I.D.s
☐ Encourage schools and police to consistently enforce laws and policies
☐ Participate in media campaign planning
☐ Participate in strategic planning
☐ Peer intervention campaign
☐ Serve as an advisor to youth-led projects
☐ Work to reduce drug and alcohol advertising
☐ Provide volunteer/in-kind support to VARSA (e.g., meeting space, technology expertise, help with newsletter, legislative advocacy, etc.)
☐ Work to change policies at the local level by talking to community officials
☐ Work to change policies at the state level by talking to legislators
☐ Other:

3.4 What would you like to get out of your participation with VARSA? *(Check ALL that apply)*

☐ Access to Data	☐ Professional networking
☐ Resources for expanded services	☐ Free exhibit opportunities at VARSA events
☐ Positive community presence for my organization	☐ Ongoing education
☐ Other:	

4. Signature and Effective Date:

I will help VARSA work to reduce and prevent underage drug and alcohol use by engaging, educating and empowering all sectors of our community and increasing collaboration and coordination of community services and resources. Upon signing, this CIA will become effective until either mutual termination or annual review.

_____ _____

Charles vanNorman, VARSA Chairperson *Member*

_____ _____

Date *Date*

Review Date 1:	*Review Date 2:*

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Reviewed by:	*Reviewed by:*
Extend CIA for another year: ☐*Yes* ☐*No*	*Extend CIA for another year:* ☐*Yes* ☐*No*
Signed by VARSA Representative:	*Signed by VARSA Representative:*
Sector Rep. Signature:	*Sector Rep. Signature:*
Notes:	*Notes:*

Washington State Department of Social & Health Services

Background Authorization

Read the attached instructions before completing this form.

SECTION 1. ENTITY INFORMATION (COMPLETED BY DSHS STAFF, PROVIDER, APPLICANT, LICENSEE, AND/OR CONTRACTOR)

1A. GIVE NAME OF PERSON OR ENTITY REQUESTING THIS BACKGROUND CHECK	1B. **SEE INSTRUCTIONS**: GIVE ENTIRE ADDRESS OF PERSON OR ENTITY REQUESTING THE CHECK	1C. **REQUIRED BY CHILDREN'S ADMINISTRATION ONLY**: GIVE NAME OF FACILITY/FOSTER HOME

2. NAME AND SIGNATURE OF PERSON REQUESTING THE BACKGROUND CHECK

PRINTED NAME: SIGNATURE:

3. A. REQUIRED ONLY FOR ECONOMIC SERVICES ADMINISTRATION:

☐ WorkFirst contract ☐ Protective Payee ☐ In-home relative ☐ In loco parentis

B. REQUIRED ONLY FOR CHILDREN'S ADMINISTRATION:

☐ State foster care ☐ Private agency foster care ☐ Adoption ☐ DCFS relative placement ☐ Contracts

☐ Subject of (or related to) CPS investigation ☐ Residential facility or child placing agency employee

C. REQUIRED ONLY FOR ADULT PROTECTIVE SERVICES:

☐ Subject involved in (or related to) APS investigation per RCW 74.34

D. REQUIRED ONLY FOR DSHS STATE EMPLOYMENT:

DSHS POSITION NUMBER _____ **(WRITE NONE IF NONE)** DSHS JOB CLASSIFICATION: _____ PERSONNEL IDENTIFICATION NUMBER: _____

☐ Permanent appointment ☐ Non-permanent appointment ☐ Work study ☐ Volunteer ☐ Student internship ☐ Layoff ☐ On-Call

4. **SEE INSTRUCTIONS**: BCCU ACCOUNT NUMBER	5A. **SEE INSTRUCTIONS:** DSHS ID NUMBER OR NAME	5B. **FOR WEB SERVICE FINGERPRINT CHECK:** BCCU INQUIRY ID NUMBER

SECTION 2. THIS SECTION IS FOR APPLICANT INFORMATION ONLY (THE PERSON TO BE CHECKED IS THE APPLICANT)

6. **SEE INSTRUCTIONS:** SOCIAL SECURITY NUMBER	7. PRINT YOUR DATE OF BIRTH (MM/DD/YYYY)

8A. SEE EXAMPLE IN INSTRUCTIONS: PRINT YOUR LAST NAME AS IT IS NOW **(WRITE NONE IF NONE)**	SEE EXAMPLE IN INSTRUCTIONS: PRINT YOUR FIRST NAME AS IT IS NOW **(WRITE NONE IF NONE)**	SEE EXAMPLE IN INSTRUCTIONS: PRINT YOUR MIDDLE NAME AS IT IS NOW **(WRITE NONE IF NONE)**
8B. PRINT YOUR LAST NAME AT BIRTH **(WRITE NONE IF NONE)**	PRINT YOUR FIRST NAME AT BIRTH **(WRITE NONE IF NONE)**	PRINT YOUR MIDDLE NAME AT BIRTH **(WRITE NONE IF NONE)**

9. PRINT OTHER LAST NAMES YOU HAVE USED AND LAST NAMES YOU HAVE BEEN KNOWN BY **(WRITE NONE IF NONE)**

10. PRINT YOUR NICKNAMES AND ALL OTHER FIRST NAMES YOU HAVE USED AND HAVE BEEN KNOWN BY **(WRITE NONE IF NONE)**

11A. Have you been convicted of any crime? If yes, fill in the blanks below. Add a page if you need more room. ☐ Yes ☐ No

Felony and gross misdemeanor crimes: _____ Degree:_____ State:_____ Conviction date: _____

11B. Do you have charges (pending) against you for any crime?
If yes, fill in the blanks below. Add a page if you need more room. ☐ Yes ☐ No

Felony and gross misdemeanor crimes: _____ Degree:_____ State:_____

12. Have you ever received a notice from a court or state agency stating that you have sexually abused, physically abused, neglected, abandoned, or exploited a child, juvenile, or adult? ☐ Yes ☐ No

13. Has a court or state agency ever denied you a contract or license; terminated, revoked or suspended your contract or license; or have you ever given up your contract or license because a court or agency was taking action against you? ☐ Yes ☐ No

14. Has a court ever written an order of protection or a restraining order lasting more than 30 days against you for abuse, neglect, financial exploitation, domestic violence, or abandonment of a vulnerable adult, juvenile, or child? ☐ Yes ☐ No

15. PRINT YOUR DRIVER'S LICENSE OR STATE IDENTIFICATION NUMBER **(WRITE NONE IF NONE)**	PRINT THE NAME OF THE STATE ON YOUR LICENSE OR ID

16. How many years have you lived in Washington State without living in another state? _____ Years / _____ Months

17. A. PRINT THE STREET ADDRESS WHERE YOU LIVE NOW CITY STATE ZIP CODE COUNTY

B. SEE INSTRUCTIONS: PRINT THE STREET ADDRESS WHERE YOU LIVED BEFORE YOUR CURRENT ADDRESS
CITY STATE ZIP CODE COUNTY

C. SEE INSTRUCTIONS: GIVE THE DAYTIME AREA CODE AND TELEPHONE NUMBER WHERE YOU CAN BE REACHED

18. I am the person named above. If I do not tell the whole truth on this form, I understand I can be charged with perjury and I may not be allowed to work with vulnerable adults, juveniles or children. My signature in box number 19 means:

- I give DSHS permission to check my background with any governmental entity and law enforcement agency.
- If a founded finding is identified, I give DSHS permission to give only my name and that a founded finding was identified to any persons or entities in Section 1.
- I give DSHS permission to give all my other background information to the persons or entities named in Section 1.
- This permission is good for 90 days from the date signed. I can change my mind about this permission in writing at any time.

19. **REQUIRED:** YOUR SIGNATURE. YOUR PARENT OR GUARDIAN'S SIGNATURE IF YOU ARE UNDER 18.	20. **REQUIRED:** TODAY'S DATE (MM/DD/YYYY)

FOR USE BY CHILDREN'S ADMINISTRATION STAFF ONLY

CAMIS files checked by on date ☐ No information found ☐ Information available

SECTION 2: You MUST fill out this section if you are the person we are checking. Note: A DSHS employee asking for a background check for an Adult Protective Services (APS) or Child Protective Services (CPS) investigation MUST fill out this section as best he or she can.

6. You MAY put your social security number (SSN) in this box. Your SSN is not required to conduct a background check. _____ (This box allows your program to insert requirements.)
7. **You MUST** fill in your date of birth.
8. **A. You MUST** put your whole name. If you do not have a name to put in this box, **you MUST** put **NONE**. SEE EXAMPLE BELOW.

EXAMPLE:		
PRINT YOUR LAST NAME AS IT IS NOW	PRINT YOUR FIRST NAME AS IT IS NOW	PRINT YOUR MIDDLE NAME AS IT IS NOW
NONE	*"Prince"*	*NONE*

B. You MUST put your whole birth name. **You MUST** put **SAME** if any of your names are the same as the names you put in box 8A.

9. **You MUST** put last names you have used or have been known by. **You MUST** put **NONE** if you have NOT used or been known by any other last names.
10. **You MUST** put any nicknames you have used. **You MUST** put **NONE** if you have NOT used any nicknames.
11. **You MUST** answer **YES** or **NO**. If your answer is **YES** to A. or B., **you MUST** fill in your conviction and pending charge information.
12. **You MUST** answer **YES** or **NO**.
13. **You MUST** answer **YES** or **NO**.
14. **You MUST** answer **YES** or **NO**. Put **YES** if the protection order lasted longer than 30 days and it was for the protection of a vulnerable adult, juvenile or child.
15. **You MUST** put your driver's license or state identification number in the box. **You MUST** put the name of the state in the box. **You MUST** put **NONE** if you do not have a driver's license or state identification number.
16. **You MUST** put the number of years and months you have lived in Washington State without living in another state or country. If you have moved out of Washington to another state or country, **you MUST** start counting the years and months from the date you moved back to Washington State. **Note**: **You MUST** ask your program if you have to get a fingerprint check.
17. **A. You MUST** fill in the address where you live now.
    B. Your program may require you give your old address. Ask your DSHS program. Put N/A in this box If NOT required by your program.
    _____ (This box allows your program to insert requirements.)
    C. Ask your program if your telephone number is required. You **MUST** put **NONE** if you do not have a telephone number.
    _____ (This box allows your program to insert requirements.)
18. **You MUST** read the statement in this box. Your signature under number 19 means you have read and agree to the statements in number 18. This background authorization form does NOT take the place of a public disclosure request for records about a founded finding. Founded finding means a state agency has taken a legal action against someone after an investigation and notice of a decision about abuse, sexual abuse, neglect, abandonment or exploitation or financial exploitation of a vulnerable adult, juvenile or child.
19. **You MUST** sign your name here. If you are NOT 18 years old, **your parent or guardian MUST** sign here.
20. **You MUST** fill in the date you signed this form.

ATTENTION APPLICANTS:
If you want to know the status of your background check form or need information about the BCCU background check process, contact BCCU at: bccuinquiry@dshs.wa.gov

ATTENTION ENTITIES AND DSHS STAFF: **You MUST** report errors in your address, telephone number or fax number to BCCU at **bccuinquiry@dshs.wa.gov** or (360) 902-0299. Put your BCCU account number in your email.

INSTRUCTION SHEET FOR FILLING OUT THE BACKGROUND AUTHORIZATION FORM

You MUST fill in ALL boxes on this form as instructed. READ the instructions for each Section and each box.

You MUST put an answer in the box. You can put NO, NOT APPLICABLE (N/A), OR NONE– except BOX number 3 –

DO NOT answer any question by putting UNKNOWN or a QUESTION MARK in the box. If you do, the form will be sent back.

Print clearly with black ink. Read each question carefully.

Check with your DSHS program to find out if you must fill in boxes marked "SEE INSTRUCTIONS"
_____ (This box allows your program to insert their requirements.)

You MUST put an answer in every box and return this form to: _____ (This box allows the person, program, or entity to insert the address or fax number where the form is to be returned.)

Most background authorization forms are sent back to the requester for the following reasons:

- Wrong form.
- Blank boxes.
- Bad handwriting.
- Missing or wrong BCCU account number.
- Person under 18 signs the form without a parent or guardian signature.
- Date signed is older than three (3) months from the date BCCU received the form.

SECTION 1: This section must be completed by the person or entity requesting this background check. An entity may be a facility, business, organization, or agency such as a Nursing Home, a Rehabilitation Center, or a DSHS Office.

If you are applying to be a licensed Adult Family Home, Boarding Home, or Nursing Home, **SKIP SECTION 1**. GO directly to SECTION 2.

1. **A.** **You MUST** put the name of the entity or person asking for the background check. An entity may be a DSHS office. A person may be someone applying for a license or a service provider contract. Ask your DSHS program to tell you what person's name or the name of the entity that is required for this box.
   _____ (This box allows your program to insert requirements.)

   B. Ask your DSHS program if you are required to fill in the address of the entity or person asking for the background check. Put N/A in this box if NOT required by your program.
   _____ (This box allows your program to insert requirements.)

   C. **This box is** ONLY for Children's Administration. Children's Administration: Fill in the name of the facility or foster home.

2. **You MUS**T print and sign your name if you are the person asking for the background check. The person who is being checked signs in box 19.

3. DO NOT WRITE ANYTHING IN THESE BOXES UNLESS you are an employee of Children's Administration, Economic Services Administration, Adult Protective Services or a DSHS hiring authority.

   D. Personnel ID Number is the permanent number assigned to every staff person by the Department of Personnel (DOP).

4. **You MUST** put your BCCU account number in this box. You can find your BCCU account number at http://www1.dshs.wa.gov/msa/bccu/index.htm. If this form is part of your application for **license** as an Adult Family Home, Boarding Home or Nursing Home, you **DO NOT** need to give the BCCU account number. You MUST do the following:
   - Adult Family home – Put an **A** in front of your license number.
   - Boarding home– Put a **B** in front of your license number.
   - Nursing home– Put an **N** in front of your license number.

5. **A.** You MUST ask your DSHS program if they require you to have an ID number or a name in this box. Put N/A in this box if NOT required by your program.
   _____ (This box allows your program to insert requirements.)

   B. DSHS ONLY – Put N/A if you are NOT a DSHS staff person using Web Service for fingerprint background checks. This ID number is for DSHS staff to track background checks. Any program may use this box for their own tracking purposes.