GEORGIA DEPARTMENT OF COMMUNITY HEALTH

STUDENT INTERN

PARTICIPATION REQUIREMENTS

"Explore what a career in State Government has to offer!"

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
INTERN PROGRAM

Purpose

The Department of Community Health (DCH) Intern Program is a valuable learning experience for college and university students in a healthcare or related career. The program is administered by the Office of Human Resources (OHR) and the length of the internship can range from a minimum of 6 weeks to a maximum of 13 weeks.

Eligibility Requirements

Students meeting the following requirements may be considered for an internship:

- He/she must be a currently enrolled sophomore, junior, senior, graduate student, or law student, or no more than one year past graduation.
- He/she must have a 2.75 GPA or higher on a 4.0 scale and be in good academic standing.
- Preference may be given to a Georgia resident or attending/ attended a Georgia college, university, or graduate school.

Disqualification Standards

Students will be disqualified from participation in the DCH Intern Program for any of the following:

- Deliberate misrepresentation or falsification of any DCH application or background information.
- Deliberate misrepresentation or omission of illegal drug history (use, sale, distribution, or harvesting/ manufacturing) in connection with disclosures.
- Prior convictions for a felony or misdemeanor of an aggravated nature.

DCH Procedures

1. Interns will conform to the dress and conduct code of the DCH.
2. The supervisors of the work unit in which the intern works will be directly responsible for the intern while on site.
3. Interns will be exposed, as much as possible, to the various operations of the assigned work unit.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
INTERN PROGRAM

Summary Report

At the conclusion of the internship, the intern will provide a written evaluation of the field experience to the intern's DCH supervisor, emphasizing the strong and weak points of the experience and any recommendations for change. Copies of the intern's evaluation will be forwarded to the intern's college or university and to the DCH intern coordinator in OHR, for filing and for dissemination to appropriate supervisory personnel

Exceptions

Exceptions to the above policy must be approved by the Office of Human Resources.

Responsibilities of Supervisor

1. Introduction to full range of work accomplished by unit; processes and procedures.
2. Completion of field placement requirements indicating:
    - Work responsibilities/ expectations
    - Work hours (at least meeting requirements of college, university, or graduate school)
3. Intern Orientation
4. Training of work roles
5. Reading List for the student (Policies & Procedures)
6. Assignment of specific projects for intern / Milestones checklist
7. Evaluation of student performance
8. Monitoring of student work & notifying OHR intern coordinator if intern fails to complete work.
9. Use the following "primary beneficiary" test to determine whether DCH must pay an intern under the Fair Labor Standards Act (FLSA) and to determine whether the Intern will be the primary beneficiary of the relationship (see Primary Beneficiary Test)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
INTERN PROGRAM

"PRIMARY BENEFICIARY" TEST

USDOL's new "primary beneficiary" test should be used by Supervisor to determine whether an intern should be paid under the Fair Labor Standards Act (FLSA). The test does not require every factor to be met, but rather considers the extent to which each factor applies.

1. The extent to which the intern and the employer clearly understand that there is no expectation of compensation. Any promise of compensation, express or implied, suggests that the intern is an employee—and vice versa.

2. The extent to which the internship provides training that would be similar to that which would be given in an educational environment, including the clinical and other hands-on training provided by educational institutions.

3. The extent to which the internship is tied to the intern's formal education program by integrated coursework or the receipt of academic credit.

4. The extent to which the internship accommodates the intern's academic commitments by corresponding to the academic calendar.

5. The extent to which the internship's duration is limited to the period in which the internship provides the intern with beneficial learning.

6. The extent to which the intern's work complements, rather than displaces, the work of paid employees while providing significant educational benefits to the intern.

7. The extent to which the intern and the employer understand that the internship is conducted without entitlement to a paid job at the conclusion of the internship

The new test is intended to offer more flexibility for unpaid internships. It is advisable to consider all factors related to an internship and ensure the intern will be the primary beneficiary of the relationship before you determine it should be unpaid.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
INTERN PROGRAM

STATEMENT OF COMMITMENT

GUIDELINES FOR DCH INTERNS

While an intern at the DCH _____, a student at

_____, will adhere to the following guidelines:

1. I will not divulge or disclose to anyone other than appropriate DCH personnel any information to which I might be exposed through my internship with the DCH. I understand that failure to follow the guidelines can lead to dismissal from the DCH intern program and/or other disciplinary or legal action.
2. I will follow the DCH policies and procedures related to the work unit to which I am assigned and as set forth by my supervisor.
3. I understand that all notes, papers and memoranda in any format concerning my internship must be reviewed by my DCH supervisor before any dissemination is made to my school or any instructor or person not an employee of the DCH.
4. During my internship, I will strive not to do anything in my personal life which would create a negative public perception of myself or the DCH.
5. I understand that during my internship I will be required to assist in administrative duties. I will ensure that all administrative work I undertake will be completed in a professional, proper and timely manner.
6. I understand that during my internship I am responsible to the DCH supervisor or his/her designee of the work unit to which I am assigned.
7. I understand that my internship can be terminated at any time without cause by a DCH supervisor.
8. I understand that I will be required to work an average of 29 hours a week during DCH's normal business hours. All duties required of me will be of a professional nature and supervised.

_____ _____
Signature of Intern Date

_____ _____
(Signature of College/University Official Approving Intern Application) Date

_____ _____
Print Name Title

Agency Use Only

_____ _____
Signature of DCH Division Director Date

_____ _____
Signature of DCH Human Resources Director Date

_____ _____
Signature of DCH Deputy Commissioner Date

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)
INTERN PROGRAM

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

I do hereby authorize a review and full disclosure of all records concerning me to any duly authorized agent of the Department of Community Health (DCH), whether such records are of a public, private, or confidential nature. I understand that the DCH may review all records concerning me at any time while I am being considered for or during my internship. Should I be offered employment with the DCH, I further understand that permission is granted to run additional background checks during my term of employment with the DCH without seeking additional consent from me.

The intent of this authorization is to give my consent for full and complete disclosure of all records of my driving history, criminal history, educational background, military personnel records, records of financial or credit institutions (including records of loans), records of commercial or retail credit agencies (including credit reports and/or rating), and any other financial statements and records wherever filled, employment and pre-employment records and records of local, state and federal criminal justice agencies.

I understand that any information obtained by a personal history background investigation which is based directly or indirectly, in whole or in part, upon this authorization will be used in determining my suitability for DCH internship, employment or employment in a governmental position of trust. I authorize the disclosure of the aforementioned personal information to any person(s) deemed by the DCH to be a participant in the determination process of such suitability. I also certify that any person(s) who may furnish such information concerning me shall not be held accountable for giving this information; and I do hereby release said person(s) from any and all liability which may be incurred as a result of furnishing such information.

A photocopy of this release form will be as valid as the original form, even though the photocopy does not contain my original signature.

I have read and fully understand the contents of this Authorization for Release of Personal Information Document.

_____ _____

Signature Date

First Name and Middle Initial	**Last Name**
Address	**City, State, Zip Code**
Telephone Number	**Male/Female**
Social Security Number	**Race**
Date of Birth	**States Lived in past five (5) years**

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Caylee Noggle, Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

CONFIDENTIALITY AGREEMENT
FOR NON-EMPLOYEES

As an intern/volunteer with the Georgia Department of Community Health ("DCH"), and as a condition of my service, I acknowledge the following terms and am aware that I will be held accountable for my conduct in accordance with the following:

1. I understand that I am responsible for complying with the DCH Policies and Procedures related to privacy and security policies and procedures developed under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

2. I will follow the highest ethical standards in the performance of my duties, in keeping with the DCH Statement of Ethics policy, which calls for me to safeguard sensitive information about vendors or potential vendors and not to show prejudice or favoritism toward vendors of potential vendors. Specifically, I will not share information with any person or entity that may result in an unfair advantage for any vendor in a DCH procurement.

3. I will treat all information received in the course of my service with DCH, which relates to the members of the health plans administered by DCH, including the Medicaid program, PeachCare for Kids and the State Health Benefit Plan, as confidential and protected health information.

4. I will use and disclose health plan member information only as necessary and appropriate to perform assigned tasks, consistent with DCH Policies and Procedures and under the direction of my DCH supervisor.

5. I will not use e-mail to transmit confidential and protected health information or sensitive i..t1formation about health plan members or vendors unless I am authorized to do so under the DCH Policies and Procedures, which assume appropriate safeguards for the information, and at the request of my DCH supervisor.

6. Upon discontinuing my service with DCH, I agree to continue to maintain the confidentiality and privacy of any information I learned while I was at DCH, to provide or return all notes, documents and files, in any format, to the DCH supervisor and to return any keys, access cards, or any other device that would provide access to DCH or its information to the DCH supervisor.

_____ _____

Name(Print) Date

_____

Signature

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Caylee Noggle, Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

FAIR CREDIT REPORTING ACT

DISCLOSURE AND AUTHORIZATION FORM

The Georgia Department of Community Health may request, or has decided to request, a consumer report to be obtained from a consumer reporting agency to assist it in making a decision pertaining to your application for employment, assignment, reclassification, transfer or retention as an employee at the Georgia Department of Community Health. The Georgia Department of Community Health may also request a consumer report for individuals who have been issued a Purchasing Card (P-Card) by the agency and for those that approve invoices for payment.

You are considered a "consumer" under the Fair Credit Reporting Act and have certain rights thereunder. A "consumer reporting agency" is a person or business that, for monetary fees, regularly assembles or evaluates consumer credit information or other information on consumers for the purpose of furnishing consumer reports. A "consumer report" is any written, oral or other communication of any information by a consumer reporting agency concerning a consumer's credit worthiness, credit standing, or credit capacity which is used or collected for the purpose of serving as a factor in establishing the consumer's eligibility for employment purposes.

The information requested may include, but not be limited to: verification of identification and/or Social Security number; checks of criminal history, if any; verification of employment, education, credentials or licenses held by you, and credit and indebtedness. Any information contained in such reports may be taken into consideration in evaluating your suitability for employment, promotion, reclassification, transfer or retention as an employee.

By your signature below, you indicate that you authorize and consent to the release of consumer reports to the Georgia Department of Community Health to be used in connection with your application for employment, promotion, reclassification, transfer or retention, P-Card users, approval of invoices at the Georgia Department of Community Health. If you fail or refuse to execute this document, no further consideration will be given to your application for employment, promotion, reassignment or retention as an employee.

Signature: _____ Date: _____

Print Name: _____ Email: _____

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Caylee Noggle, Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

Authorization to Check Educational Credentials

Please provide the last name(s) used at all colleges and universities, as well as any technical schools attended. I understand that this verification is part of the hiring process.

Name:			
Social Security No.:		Date of Birth:	
EDUCATIONAL INSTITUTIONS			
School Attended:			
Location:			
Graduation Date:		Degree/Certificate:	
Name Used (if different from above):			
School Attended:			
Location:			
Graduation Date:		Degree/Certificate:	
Name Used (if different from above):			
School Attended:			
Location:			
Graduation Date:		Degree/Certificate:	
Name Used (if different from above):			
I authorize the Department of Community Health and its agents to verify any or all of my school (e.g., high school, college, university, technical school) attendance, certificates, diplomas, or degrees.			

DEPARTMENT OF COMMUNITY HEALTH
AUTHORIZATION TO CONDUCT
CRIMINAL HISTORY & BACKGROUND CHECK FOR TEMPORARY ASSIGNMENTS

PERSONAL DATA (Please Print)

NAME: _____ SSN: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____ EMAIL: _____

SEX: _____ RACE: _____ HEIGHT: _____ WEIGHT: _____

JOB TITLE: _____

DIVISION: _____ SECTION/UNIT: _____

Have you ever been convicted by Federal, State, or other law-enforcement authorities, for any violation of any federal law, state law, county or municipal law, regulation, or ordinance? (Do not include anything that happened before your sixteenth birthday. Do not include minor traffic violations for which a fine of $300.00 or less was imposed. All other convictions must be included even if they are pardoned.)
☐ Yes ☐ No If the answer is YES, state the reason convicted, the date convicted and the place where convicted.

Charge on which convicted	Date Convicted	Name of Court & Place Where Convicted	Pardoned (Yes or No)

Are there any pending charges against you by Federal, State, or other law enforcement authorities, for any violation of any federal law, State law, county or municipal law, regulation or ordinance? (Do not include anything that happened before your sixteenth birthday. Do not include minor traffic violations for which a fine of $300.00 or less would likely be imposed.)
☐ Yes ☐ No If the answer is YES, provide the following information.

Violation(s) Charged	Date Charged	Name of Court & Place Where Pending

Attach a separate sheet if more space is needed.

Iy signature below evidences my understanding that I am being considered for a temporary assignment with the Department of Community Health and that a criminal history and/or financial background check will be conducted on me. I further understand that I am required to disclose any pending charge or conviction for any crime other than minor traffic offenses including any drug-related charges and any charges relating to driving while under the influence.

I also understand that if I fail to disclose such information and falsify documents that I shall be released from my assignment and disqualified from employment with the Department of Community Health.

I hereby authorize the Department of Community Health to receive any criminal history and/or financial record information pertaining to me, which may be in the files of any federal, state or local agency or credit bureau. This authorization is valid for 90 days from date of signature.

_____ _____

Signature of Employee Date

I consent to the following background check(s): *Please initial*

☒ Criminal Check _____

☒ Financial Check _____

SWORN TO AND SUBSCRIBED BEFORE ME:

This _____ day of _____ , 20____ _____

(Notary Public Signature and Seal)

My commission expires _____

FORM 023-2 (Rev. 04-01-2013)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

State of Georgia

STATE SECURITY QUESTIONNAIRE AND LOYALTY OATH

NOTICE TO APPLICANTS/EMPLOYEES: The Sedition and Subversion Activities Act of 1953 (Ga. Laws, 1953) as amended, requires each applicant/employee to complete and sign, prior to his/her employment in State Government, a questionnaire which is designed to establish that there are no reasonable grounds to believe that he/she is a subversive person. A subversive person is defined as one who commits acts, advocates, or teaches the overthrow of the government of the United States or the government of the State of Georgia by force or violence, or who is a knowing member of a subversive organization. Georgia Code 45-3-11 requires all employees of State government to take an oath that they will support the Constitution of the United States and the Constitution of the State of Georgia.

***INSTRUCTIONS*: All items must be completed in blue or black ink. If more space is needed for any answer, continue under #10. This questionnaire and loyalty oath will be filed in the employee's personnel file.**

STATE SECURITY QUESTIONNAIRE

1

LAST NAME	FIRST NAME	MIDDLE NAME	PHONE NO.
			( )

MAIDEN NAME	DATES USED	NICKNAMES	DATES USED
OTHER NAMES, INCLUDING ALIASES & FORMER MARRIAGES	DATES USED		DATES USED
	DATES USED		DATES USED

2

ADDRESS (No and Street of Residence)	APT NO.	CITY	STATE	COUNTY	ZIP CODE

3

DATE OF BIRTH	U.S. CITIZEN: Yes ☐ No ☐ Nationality:_____	RACE	SEX

4

Are you now or have you been within the last ten (10) years a member of any organization which to your knowledge at the time of membership advocates or has as one of its objectives, the overthrow of the government of the United States or of the government of the State of Georgia by force or violence? Yes ☐ No ☐
If "Yes", state the name of the organization and your past and present membership status including any offices held therein.

_____

_____

NOTE: If the answer to the above question is "Yes" and the employing authority deems further inquiry necessary, you will be notified of such determination. No action adverse to your application will be taken because of an affirmative answer until after such an inquiry, with notice to you and an opportunity for you to present evidence, and only if the result of such inquiry brings your application within the prohibition within the Sedition and Subversive Activities Act of 1953.

5

LIST CHRONOLOGICALLY ALL OF YOUR PREVIOUS RESIDENCES FOR THE PAST TEN YEARS

DATES		STREET	City	State
From	To			

6

LIST NAMES AND ADDRESSES OF THE FOLLOWING

SPOUSE	(MAIDEN NAME)	ADDRESS
FATHER		ADDRESS
MOTHER		ADDRESS

7	**MILITARY SERVICE: (Past or Present)**						
	SERIAL NUMBER	BRANCH	ACTIVE SERVICE		ACTIVE OR INACTIVE RESERVE		DISCHARGED
			From	To	From	To	Honorably ☐ Dishonorably ☐ Other ☐ **If Discharge other than Honorable, explain in #10.**

8	Have you ever been convicted by Federal, State, or other law enforcement authorities, for any violation of any Federal law, State law, county or municipal law, regulation or ordinance? (Do not include anything that happened before your sixteenth birthday. Do not include minor traffic violations for which a fine of $35.00 or less was imposed. All other convictions must be included even if they are pardoned.)_____YES_____NO. **If the answer is Yes, state the reason convicted, the date convicted, and the place where convicted.**			
	CHARGE ON WHICH CONVICTED	DATE CONVICTED	NAME OF COURT & PLACE WHERE CONVICTED	PARDONED (yes or no)

9	Are there any charges now pending against you by Federal, State, or other law enforcement authorities, for any violation of any Federal Law, State law, county or municipal law, regulation or ordinance? (Do not include anything that happened before your sixteenth birthday. Do not include minor traffic violations for which a fine of $35.00 or less would likely be imposed.)_____YES_____NO. **If the answer is YES, provide the following information:**		
	VIOLATION CHARGED	NAME OF GOVERNMENT	NAME OF COURT & LOCATION WHERE PENDING

10	**SPACE FOR CONTINUING ANSWERS OR EXPLANATIONS: (Show item numbers to which answers or explanations apply. Attach a separate sheet if more space is needed.)**

NOTE: Before signing this form, check all answers and explanations to see that you have answered all questions fully and correctly.

LOYALTY OATH

I,_____. a citizen of_____
and being an employee of the Department of Administrative Services and the recipient of public funds for services rendered as such employee, do hereby solemnly swear and affirm that I will support the Constitution of the United States and the Constitution of the State of Georgia.

AFFIDAVIT OF VERIFICATION

State of Georgia, County of_____ (where notarized)

I,_____ (name of applicant/employee), declare under penalties of false swearing that I am the person who completed this document. I have read, know, and understand the contents of this document. The answers and information furnished by me on this document, including any attachments, are true and correct.

SWORN TO AND SUBSCRIBED BEFORE ME:

This_____day of_____,_____ _____
(Signature of Affiant)

_____
_____(Notary Public)

My commission expires: _____

DCH POLICIES AND PROCEDURES ACKNOWLEDGEMENT
(DCH WORKERS WHO ARE NOT DCH EMPLOYEES)

SFY2022

Initials	Date	Policy No	Title, Date of Last Revision	Policy Owner
		312	Inclement Weather [05-08-18]	Office of Human Resources
		401	Code of Ethics and Conflict of Interest Policy [01-26-11]	General Counsel
		402	DCH Ethics in Procurement [04-02-12]	General Counsel
		410	Standards of Conduct [07-17-17]	Office of Human Resources
		413	Unlawful Harassment [07-17-17]	Office of Human Resources
		415	Drug Free Workplace [02-11-19]	Office of Human Resources
		418	Use of State Property, Fax Equipment, Pagers, Vehicles, and Other Resources [05-16-00]	Office of Human Resources
		419	Appropriate Use of Information Technology Resources [08-16-12]	Information Technology
		420	Control of Telephone Use and Expenditures [4-01-00]	Office of Human Resources
		425	Appropriate Use of Social Media [07-27-17]	Office of Human Resources
		432	Unlawful Discrimination Complaint Procedure [04-01-00]	Office of Human Resources
		435	Managing Authorization, Access and Control to Information Systems and Request for Network Access Form [08-16-12]	Information Technology
		437	Sexual Harassment [03-29-19]	Office of Human Resources
		520	Safety and Security [11-19-18]	Office of Human Resources
		901	Authorization for Release of PHI [02-19-18]	General Counsel
		902	Amending PHI [02-19-18]	General Counsel
		904	Complaint Process for Violation of DCH Privacy Practices [02-19-18]	General Counsel
		905	Protected Health Information Disclosure Tracking [02-19-18]	General Counsel
		906	HIPPA Documentation Requirements [02-19-18]	General Counsel
		907	Individual Access to PHI [02-19-18]	General Counsel
		908	Minimum Necessary for Disclosure of PHI [03-02-18]	General Counsel
		909	Notice of Privacy Practices [02-19-18]	General Counsel
		910	PHI Safeguards Standards [02-19-18]	General Counsel/ InformationTech.
		911	Sanctions for Breach of Confidentiality [03-02-18]	General Counsel
		912	Training of HIPPA Privacy Awareness [02-19-18]	General Counsel
		913	Verification of Identity& Authority to Access PHI [03-02-18]	General Counsel
		914	Secure Transport and Receipt of Physical Media Containing Protected Health Information [03-02-18]	General Counsel
		915	Privacy & Security Incident Response [03-27-18]	General Counsel

DCH POLICIES AND PROCEDURES ACKNOWLEDGEMENT (DCH WORKERS WHO ARE NOT DCH EMPLOYEES)

SFY2022

Instructions: Sign, Date and Return to your Division Executive Director's Administrative Assistant, who will collect all DCH Policies and Procedures Acknowledgement Forms and forward them to the Office of Human Resources (OHR).

Non-Employee DCH Worker's Acknowledgment (Complete only if you are an employee of an entity other than DCH, but work for DCH on assignment and regularly work in DCH workspace)

I am aware of and agree to comply with the DCH Policies and Procedures listed above.

DCH Worker (Non-Employee) Name: _____

(Print)

DCH Worker (Non-Employee) Name: _____

(Signature)

Date: _____

Name of Legal Employer: _____

Name of DCH Employee to whom you report: _____

Rev. 11/15/2019