Allina Health
NEW ULM MEDICAL CENTER

Dear Applicant:

There are a number of items enclosed that will need to be returned in order for you to be considered as a volunteer at New Ulm Medical Center.

Application to Volunteer:

- Please fill out the entire application.
- Please be sure to obtain hard copies of your immunizations from your provider or MyChart if you have access to your electronic medical record and send them in with your application.
    - Attach the copy of immunizations to your application.

Background Study information and forms:

- Please read through the privacy notice.
- Fill out the background study form.
- Sign the background study authorization form.

New Ulm Medical Center Volunteer Requirements:

- Ongoing education and training as requested by department.
- Annual education completion.

Notice:

- Volunteer placement will depend on where the needs are the greatest.
- We will take volunteers who are interested in those areas first and then place volunteers in other locations as needed.
- Background studies will be completed prior to you becoming a volunteer.
- We do not do Service hours.

Thank you for your consideration to volunteer here at New Ulm Medical Center.

Vonda Dulas
507-217-5360
vonda.dulas@allina.com

New Ulm Medical Center Volunteer Application Form

Name:_____
(last) (first) (middle initial)

Address:_____
(street) (city, state) (zip)

Birth Date (year is optional):_____Phone: _____

Email address: _____

In emergency, notify: _____ Relationship: _____Phone: _____

Education/Work Experience

Employer:_____Position: _____How long?_____

Work Phone:_____ May we contact you at work? Y or N

Retired from:_____Position: _____

Level of education completed: _____Degree: _____

If attending college, name of college: _____

Do you have previous experience as a volunteer? _____

Where and what were your responsibilities? _____

_____

Why did you choose the New Ulm Medical Center for volunteer work? _____

_____

Volunteer Availability

Volunteer shifts are typically one time per week or month, scheduled according to department need and volunteer availability. Volunteers are asked to make a minimum commitment of one shift per month for 12 months, or 50 hours for the next year.

Volunteer job(s) you would prefer:

☐ Virginia Piper Cancer Institute ☐ Hospital Front Desk ☐ Clinic Front Desk

☐ Courage Kenny Rehabilitative Institute (PT) ☐ Same Day Surgery

Please check all of the times you are available to volunteer:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							

Additional comments, skills, training you feel pertinent to your application: _____

_____

How did you learn about the New Ulm Medical Center Volunteer Program? _____

Personal/Professional Reference

IMPORTANT: Please enclose a letter of recommendation OR complete the reference information below. Application without a reference contact will not be considered. (References may not be a relative).

Name: _____ Phone: _____

Volunteer Health Record

Please fill out attached form for infectious disease and immunization tracking.

Initial here once completed: _____

Do you have any disabilities that might limit your volunteer duties? This information will be used to help with appropriate volunteer placement. _____

Physician's Name: _____ Phone: _____

The information in this application is accurate and correct to the best of your knowledge. Your signature indicates your approval for us to verify references provided.

Failure to fully and truthfully complete this application may result in denial of volunteer service or termination from the service.

New Ulm Medical Center Volunteer Services IS NOT obligated to provide placement nor are you obligated to accept the position offered.

SIGNATURE: _____ DATE: _____

New Ulm Medical Center is committed to Equal Opportunity Volunteer Placements

Return to:

New Ulm Medical Center
Volunteer Coordinator
1324 5th North Street
New Ulm, MN 56073
507-217-5360

Health Clearance Instructions

Welcome to the Allina Health Volunteer Program! Your application has been received and we are excited that you will be joining our Allina Health team.

To help protect our patients, employees, students, visitors, and other volunteers, as well as be in compliance with state and federal regulations, Allina Health requires all incoming volunteers to be screened for Tuberculosis and provide immunization status before volunteering.

1. **Complete** the attached Allina Health Volunteer Health Clearance Form.

2. **The following immunization information will be given to Courtney Kuehn, RN Employee Occupational Health (EOH).**
   Please make every effort to locate **all immunization information** from other sources, such as your health care provider or school. Provide the following immunization records:
   - ☐ Mumps, Rubella, Rubeola (MMR)
   - ☐ Varicella Vaccine (Chicken pox)
   - ☐ Tetanus, Diphtheria, Pertussis (Tdap)
   - ☐ Tuberculosis skin or blood test (Mantoux or QFT)
   - ☐ Influenza / Flu vaccination

   The completed forms and immunization information will be reviewed. If documentation of the required immunization information is not received, a nurse will identify what **blood tests** are needed in order for the volunteer request to be approved. If he/she has any questions, you will be contacted.

3. **Vonda will send you a copy of the required testing. A copy will also be submitted to lab.**

4. **Contact NUMC Lab at 507-217-5366 to schedule a blood collection appointment.**

5. If any follow-up testing and/or immunizations are required, EOH will contact you to discuss.
   All vaccinations and blood draws are free of charge to you.

6. When all health clearance requirements are completed, volunteer services will be notified, and they will contact you to set up your volunteering.

Applicants under the age of 18 (Minors):
For applicants under 18 years of age, a parent or guardian must sign the "Consent to Volunteer (found on page 2 of the Health Clearance Form) in order for you to receive necessary vaccinations from EOH. If a parent/guardian has not signed the consent or does not accompany the minor, EOH will contact the parent/guardian via phone to obtain verbal consent. If unavailable by phone, the required vaccinations will not be given and you must come back another time.

If you have questions regarding the screening process, please call NUMC's Employee Occupational Health Nurse at 507-217-5454.

Thank you!

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Volunteer Health Clearance Form

Please fill out form completely and <u>return with all required immunization records to your volunteer coordinator.</u> Any questions in regards to completion of this form, please contact Employee Occupational Health at 612-262-4490.

****Your social security number is required to process health clearance in the Allina Health System****

Name:_____ SSN# (required):_____Date of Birth:_____

Phone Number (daytime): _____Email:_____

Volunteer Site: _____ Places you have lived outside USA: _____

PLEASE READ THROUGH ALL THE FOLLOWING QUESTIONS.
CHECK ALL ANSWERS THAT APPLY TO YOU.

Tuberculosis (TB)

_____ I have never had a skin test or blood test for TB (Mantoux). (If you have never had a test, Allina will order proper testing free of charge as part of your on-boarding)
_____ I have had a negative skin test for TB
_____ Approximate date of last test (month and year) _____
_____ I have received BCG vaccine (uncommon in U.S.)
_____ I have had a positive skin test or blood test for TB
_____ not treated _____ treated with isoniazid (INH) or other medication
Dates of treatment: _____ Duration of treatment_____
_____ I have had TB
_____ I have had a reaction (e.g. redness, swelling or bump) to TB skin test. If yes, describe:
_____

Current Health Status – Any current symptoms such as:

____fever____cough over 3 weeks_____bloody sputum_____night sweats____weight loss____fatigue____poor appetite
____unexplained chills____chest pain

____**No current symptoms**

Mumps (Include a copy of proof of required vaccination)

_____ I have had two Mumps vaccines. If yes, have documentation that you had it yes ☐ no ☐
_____ I have been tested for Mumps antibody. Date _____
Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had Mumps or been vaccinated

Rubella (German Measles) (Include a copy of proof of required vaccination)

_____ I had rubella vaccine. If yes, have documentation that you had it? yes☐ no ☐
_____ I have been tested for rubella antibody. Date _____
Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had German measles or been vaccinated

Measles (Rubeola) (Red Measles) (Include a copy of proof or required vaccination)

_____ I have had Measles vaccine. If yes, have documentation that you had it yes ☐ no ☐
_____ I have been tested for rubeola antibody. Date _____
Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had Measles (Rubeola) or been vaccinated

Chickenpox (Include a copy of proof or required vaccination)

_____ I have had chickenpox (Varicella) vaccine.
If yes, do you have documentation of two vaccinations? yes ☐ no ☐
_____ I have been tested for chickenpox immunity.
If yes, do you have documentation of lab titer results? yes ☐ no ☐
_____ I don't know if I have had Chickenpox/and or shingles or been vaccinated

Tetanus / Diphtheria / Pertussis (Include a copy of proof or required vaccination)

____ I had a primary series of 3 or 4 doses of DT, DPT, Td, or Tetanus vaccine
_____ Date of last tetanus vaccine "booster"
_____ Date of last documented DPT vaccine
____ I had a single adult does of Tdap vaccine
_____ Date of documented Tdap vaccine
_____ Allergy
_____ Unknown

Hepatitis B (Include a copy of proof of vaccination, if available)

_____ I have had Hepatitis B. If yes, date _____.
_____ I have had the Hepatitis B vaccine. If yes, approximate dates:
Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____
Other (describe) _____
_____ I have been tested for Hepatitis B antibody. If yes, date _____.
Where tested_____
Was test: positive ☐ negative ☐ don't know ☐
_____ I have had Hepatitis B surface antigen test. If yes, date _____.
Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had Hepatitis or been vaccinated.

COVID Vaccine (Include a copy of proof of vaccination, if available)

_____
_____ I have NOT had COVID vaccine.

_____ I have had the COVID vaccine(s). If yes, please include all dates you have received.

Vaccine Date 1:_____ Manufacturer _____

Vaccine Date 2:_____ Manufacturer _____

Vaccine Date 3:_____ Manufacturer _____

Vaccine Date 4:_____ Manufacturer _____

Vaccine Date 5:_____ Manufacturer _____

Vaccine Date 6:_____ Manufacturer _____

Influenza Vaccine: - For current flu season (August-March). (Include a copy of proof or required vaccination)

_____ I have NOT had the Influenza vaccine.

_____ I have had the Influenza vaccine. If yes, date

Date:_____
Location received: _____

Applicant Name: _____

Immune Status: People with weakened immunity are at risk for more serious disease due to infection and may also pass infection more easily to others. ***Check if you have had the following:***

_____ Uncontrolled HIV with CD4 count <200 or HIV patients not on antiretroviral medication
_____ Currently received cancer treatment
_____ With solid organ transplant on anti-rejection medication
_____ Recent bone marrow transplant recipients with <500 absolute neutrophil count
_____ With genetic immune deficiencies
_____ On 30mg prednisone for 30 or more days
_____ On immunosuppressants (mycophenolate, sirolimus, cyclosprine, tacrolimus, etanercept, rituximab, daclizumab, basiliximab, ocrelizumab, ofatumumab, obinutuzumab)

CONSENT:

VOLUNTEER NAME (Please Print): _____

VOLUNTER SIGNATURE _____ DATE: _____

☐ By checking this box, I consent for a detailed voicemail to be left in regards to any type of follow up needed.

PARENTAL CONSENT **required if applicant under 18 years old:**

_____ DATE: _____
(*parent/guardian signature*)

By signing above, you are consenting to have your child receive the necessary lab tests and/or immunizations in order to be cleared to work as a volunteer.

VOLUNTEERS please provide copies of all prior immunization records and/or lab titers listed below if you have available to you

- **COVID**
- **Influenza**
- **TB skin test or QFT (TB blood test)**
- **Chest x-ray only if positive TB history**
- **MMR (Measles, Mumps, Rubella)**
- **Hepatitis B**
- **Tdap or TD**
- **Chicken Pox (Varicella)**

Choose the lab you would like to go to. **Wait 3 days to allow your order to be received and set up**. You can report to the lab within 3 to 14 business days after you submit your request. **Please note, all lab tests in which are ordered are FREE of charge. If not contacted by EOH, follow the 3 day directions.**

Blood tests that may be ordered are:

1. **Tuberculosis screening (QFT-Quantiferon Gold Test)**
2. **Immunity assessment to Measles, Mumps, Rubella, and Chicken Pox (varicella)**

Applicant Name: _____

AUTHORIZATION TO ACCESS AND USE IMMUNIZATION RECORDS

As a benefit to you, Employee Occupational Health (EOH) will obtain your immunization information directly from state immunization registries on your behalf with your consent. If you would like to take advantage of this service, please complete the below Authorization to Access and Use Immunization Records form. Completing this authorization is not required for employment and/or volunteering, but without this authorization, you will need to obtain all of your immunization records on your own. If EOH does not receive your immunization records in a timely manner, your start date may be delayed.

I, _____, understand that I am required to provide immunization records for required immunizations to Allina health System ("Allina Health") as a condition of employment and/or volunteering at Allina Health to protect patients, health care workers, visitors and the community. Allina Health's Employee Occupational Health Department provides a service to Allina Health employees and volunteers by offering and coordinating immunizations for Allina Health employees and other workforce members. To aid in this process, I authorize Allina health and its Agents to obtain immunization information for me on my behalf from state immunization registries, including, but not limited to , the Minnesota Immunization Information Connection (MIIC) and the Wisconsin Immunization Registry (WIIR).

First and Last Name: _____

Signature: _____

Signature of Patent/Guardian (Parental Consent is required if under 18 years old): _____

Date of Birth (MM/DD/YYYY): _____

Date: _____

This consent will continue forever unless I cancel it in writing by:
Email
employeeoccupationalhealthserv@allina.com
OR
By Mail:
Employee Occupational Health
3960 Coon Rapids Blvd NW
Suite 215
Coon Rapids, MN 55433

If I cancel my consent, it will not apply to releases that have already been made.

☐ I decline to authorize Allina Health to obtain information for me on my behalf from state immunization registries.

Lab locations to get your lab work completed.

Location	Hours	Address
☐ **Abbott North Western Hosp. (Minneapolis)**	6am-6pm M-F 7am-1:30pm Sat	800 East 28th St Minneapolis, MN 55407
☐ **Abbott Northwestern Center for Out Patient Care EDINA**	8am-5pm **Call For Appointment** 952-914-8046	8100 W. 78th St Suite 110 Edina, MN 55439
☐ **Buffalo Hospital**	7am-3pm M-F **Call For Appointment** 763-684-7855	303 Caitlin St Buffalo, MN 55313
☐ **Cambridge Medical Center**	7am-3pm M-F	701 South Dellwood St Cambridge, MN 55008
☐ **Faribault AHC**	7:30am-7pm M-F	100 State Ave Faribault, MN 55021
☐ **Hastings AHC**	8am-3:30pm M-F	1880 N. Frontage Road Hastings, MN 55033
☐ **Mercy Hospital (Coon Rapids)**	6am-6pm M-F 7am-1:30pm Sat	4050 Coon Rapids Blvd Coon Rapids, MN 55433
☐ **New Ulm**	8am-5pm M-F **Call For Appointment** 507-217-5366	1324 Fifth North St New Ulm, MN 56073
☐ **Northfield AHC**	8am-5pm M-F	1400 Jefferson Rd Northfield, MN 55057
☐ **Owatonna Hospital**	8am-2pm M-F Report to ED Registration Desk	2250 NW 26th St Owatonna, MN 55060
☐ **River Falls Hospital**	6:30am-2:30pm M-F	1629 E. Division St River Falls, WI 54022
☐ **St. Francis Hospital (Shakopee)**	9:30am-4pm M-F	1455 St. Francis Ave Shakopee, MN 55379
☐ **Mercy Hospital—Unity Campus (Fridley)**	6am-6pm M-F 7am-1:30pm Sat	550 Osborne Rd Fridley, MN 55432
☐ **United Hospital (St. Paul)**	6am-6pm M-F	333 North Smith Ave St. Paul, MN 55102
☐ **West Health (Plymouth)**	7:30am-4pm M-TH 7:30am-2pm F	2855 Campus Dr Suite 215 Plymouth, MN 55441

Complete this form and return to the Volunteer Office.

Background Study Form

MINNESOTA DEPARTMENT OF HEALTH LICENSED FACILITIES
SUPPLEMENTAL NURSING SERVICES AGENCIES, EDUCATIONAL PROGRAMS, TEMPORARY EMPLOYMENT AGENCIES, PROFESSIONAL SERVICES AGENCIES

INSTRUCTIONS:

- **PRINT ALL INFORMATION:** After completing this form, return to the volunteer office. Information will be submitted to the Department of Human Services via NETStudy.
- **OPTIONAL:** Items marked with an asterisk (*) and below the solid black line are optional. All other information is required.
- **BIRTHDATE:** Enter date of birth in the format MMDDYY (example Dec 31, 1970 would be 12311970)
- **DUAL NAMES:** Separate dual names with a space (example "Mary Louise" or Smith Johnson").
- **TITLES/INDICATORS:** Do not include titles ("D", "Sister", "Father"), or educational ("PhD", "MD", etc), generational ("Jr", "Sr", "II", "IV", etc.) or professional indicators ("LICSW", "LP", etc.)

FIRST NAME	MIDDLE NAME	LAST NAME

OTHER FIRST NAMES YOU HAVE USED	OTHER LAST NAMES YOU HAVE USED

ADDRESS

CITY	STATE	ZIP CODE

BIRTHDATE			GENDER
2-Digit Month	2-Digit Day	4-Digit Year	○ MALE ○ FEMALE

STATE DRIVER'S LICENSE NUMBER OR STATE IDENTIFICATION NUMBER →	(PLEASE PRINT CLEARLY)

TELEPHONE				–				–				

Allina Health
NEW ULM MEDICAL CENTER

Background Check Authorization for Allina Health Volunteers

By signing below, I authorize Allina Health, including its subsidiary and affiliate corporations, to obtain a consumer report in connection with my application for a volunteer role, or, as allowed by law, at any time during my volunteer role and from a consumer reporting agenda (CRA) other than Verified Credentials, Inc.

For the purpose of preparing a background check for Allina Health, and only for that specific purpose, and subject to all laws protecting my information and individual privacy, I also authorize that the following information may be disclosed to the CRA as needed to compile the report: my past and present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military, credit bureaus; testing facilities; and motor vehicle records agencies. By signing below, I acknowledge the information that can be disclosed to the CRA, if and only as allowed by law, includes information related to my criminal background, motor vehicle history, employment and earnings history, education, personal references, character, mode of living, credit background, civil judgements or liens, military service, and professional credentials and licenses.

A volunteer opportunity with Allina Health is contingent upon a satisfactory background investigation. If I become a volunteer, I authorized Allina Health to order additional background reports while volunteering with Allina Health related to any of the above issues without asking me for my authorization again.

I may receive a copy of any consumer report obtained by Allina Health at no expense to me. I understand that I may request additional information of the nature of the report upon written request to the CRA. These searches will be conducted by: Verified Credentials, Inc., 20890 Kenbridge Court, Lakeville, MN 55044, 800-473-4934, www.verifiedcredentials.com. Check this box if you would like a free copy of your background report: □ Yes □ No

A copy of this authorization has the same validity as the original.

Identity information and Address History		
First Name	Middle Name	Last Name
Former name(s) or alias you have used in the past (including maiden name):		
Date of Birth*	Social Security Number*	
Phone	Email Address	
Please list ALL of the addresses where you have lived during the last 7 years		
Current:		
Previous:		
Previous:		
Previous:		
Signature		

** This information is used for identification purposes only.*

Allina Health
NEW ULM MEDICAL CENTER

Background Study Authorization

To Whom It May Concern:

I authorize Allina Hospitals & Clinic, including its subsidiary and affiliate corporations ("Allina"), to obtain a background study in connection with my application to volunteer.

Any offer to volunteer is contingent upon a satisfactory background investigation.

I understand that a copy of this background check will be mailed to me at no expense.
A copy of this authorization has the same validity as the original.

Signature: _____Date: _____

Print Name: _____

Date of Birth: _____

Minnesota Department of **Human Services**

MINNESOTA DEPARTMENT OF HEALTH LICENSED FACILITIES
SUPPLEMENTAL NURSING SERVICES AGENCIES, EDUCATIONAL PROGRAMS, TEMPORARY EMPLOYMENT AGENCIES, PROFESSIONAL SERVICES AGENCIES

BACKGROUND STUDY PRIVACY NOTICE

Because the Minnesota Department of Human Services is requesting that you provide private information about yourself, the Minnesota Government Data Practices Act requires that you be informed of the following:

1. Purpose and intended use of the information: Minnesota Statues, section 144.057, requires the Minnesota Department of Human services (DHS) to conduct background studies on individuals who have direct contact with patients and residents in hospitals, boarding care homes, outpatient surgical centers, nursing homes, home care agencies, residential care homes, board and lodging establishments registered to provide supportive or health supervision services, individuals employed by supplemental nursing services agencies, and controlling persons of a supplemental nursing services agency; and all other employees in nursing homes. The background studies are to be completed according to the requirements in Minnesota Statutes, chapter 245C. The information requested will be used to perform a background study of you that will include at least a review of criminal conviction records held by the Minnesota Bureau of Criminal Apprehension and records of substantiated maltreatment of vulnerable adults and children. DHS may also later require you to submit additional information and/or your fingerprints if necessary to complete your background study. For all individuals who are subject to background studies by DHS, the corrections system will report new criminal convictions for disqualifying crimes to DHS. County agencies and the Minnesota Department of Health report substantiated findings of maltreatment of minors and vulnerable adults to DHS.

2. Whether you may refuse or are legally required to provide the information: Minnesota Statutes, chapter 245C, states that the individual who is the subject of a study must provide sufficient information to ensure an accurate background study.

3. Known consequences that may arise from supplying the information: Individuals who have histories with the characteristics identified in Minnesota Statues, chapter 245C, will be disqualified from positions allowing direct contact with (and, where applicable, access to) persons receiving services. Health-related licensing boards will make a determination whether to impose disciplinary or corrective action on individuals regulated by health-related licensing boards who have been determined to be responsible for substantiated maltreatment. Individuals who do not have disqualifying characteristics will not be disqualified.\

4. Known consequences that will arise from refusing to supply the requested information: Only items identified as “optional” may be left blank. Refusal to provide the information necessary to ensure an accurate and complete background study will result in your disqualification and an order to the agency or facility to remove you from any position allowing direct contact with (and, where applicable, access to) persons receiving services.

5. Identification of other agencies or entities authorized to receive this information: The information you provide will be shared with the Minnesota Bureau of Criminal Apprehension. If DHS has reasonable cause to believe that other agencies may have information pertinent to a disqualification, the information may also be shared with county attorneys, county sheriffs, courts, county agencies, local police, the Federal Bureau of Investigation, the Office of the Attorney General, agencies with criminal record information systems in other states, and juvenile courts. Background study results may be shared with the Minnesota Department of Health, the Minnesota Department of Corrections, the Office of the Attorney General, non-licensed personal care provider organizations, and health-related licensing boards. If you have a disqualifying characteristic, the facility will be told only that you are disqualified and will not be told what caused your disqualification, unless you were disqualified for refusing to cooperate with the background study or for serious and/or recurring maltreatment of a minor or vulnerable adult. The information about you received as part of a background study is classified as private data and, except for the agencies noted, cannot be shared without your consent.

6. A. If CURRENT background study results in a disqualification that is set aside upon reconsideration: If you are disqualified as a result your background study, and you request reconsideration and your disqualification is set aside for the program/agency that initiated the current background study, subsequent background studies initiated by other programs/agencies may result in the disqualification being set aside for other programs/agencies when the following criteria are met:

    1. While you are disqualified, you are not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;
    2. the program that initiates the subsequent background study is licensed or regulated under the same provisions of law and rule as the program for which your disqualification was previously set aside;
    3. the commissioner has not received any new information to indicate that you may pose a risk of harm to any person served by the program; and
    4. the previous set aside was not limited to a specific person(s) receiving services.

    If the above criteria are met, the notice of disqualification sent to the program/agency that initiates the subsequent background study will state that you are disqualified and will include the reason you are disqualified. It will also state that your disqualification has been set aside for their program/agency, and that upon request, and without your consent, information about the factors that were the basis for the decision to set aside your disqualification are available to them. (§245C.22, subd. 5)

6 B. If a PREVIOUS background study resulted in disqualification that was set aside: If you were the subject of a previous background study which resulted in your disqualification, and your disqualification was set aside upon reconsideration, DHS will review the information in your record in connection with your current background study and determine whether the following criteria are met:

    1. While you are disqualified, you are not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;
    2. the program that initiated the current background study is licensed or regulated under the same provisions of law and rule as the program for which your disqualification was previously set aside;
    3. the commission has not received any new information to indicate that you may pose a risk of harm to any person served by the program; and
    4. the previous set aside was not limited to a specific person(s) receiving services.

    If the above criteria are met, the notice of disqualification set to the program/agency that initiated the current background study will state that you are disqualified and will include the reason you are disqualified. It will also state that your disqualification has been set aside for their program/agency, and that upon request, and without your consent, information about the factors that were the basis for the decision to set aside your disqualification are available to them. (§245C.22, subd. 5)