



<b>FOR OFFICE USE ONLY:</b>	
Accepted:	Verified by:
STATUS:	L/SCAN DATE:
COMMENTS:	

**PROVIDER APPLICATION FORM**

<b>SOCIAL SECURITY NO.:</b>			
<b>FIRST NAME:</b>		<b>MIDDLE INITIAL:</b>	
<b>LAST NAME:</b>			
<b>HOME PHONE:</b>		<b>CELL PHONE:</b>	
<b>PHYSICAL ADDRESS:</b>	<b>City:</b>	<b>State: CA</b>	<b>Zip:</b>
<b>MAILING ADDRESS:</b>	<b>City:</b>	<b>State: CA</b>	<b>Zip:</b>
<b>DATE of BIRTH:</b>	<b>GENDER (Optional):</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>PROOF of IDENTIFICATION:</b>	<input type="checkbox"/> CA ID#:	Expiration Date:	
	<input type="checkbox"/> CA DL#:	Expiration Date:	
	<input type="checkbox"/> Passport #:	Expiration Date:	
	<input type="checkbox"/> Other ID:	Expiration Date:	
<b>EMAIL: (required for all registry providers)</b>			

**DAYS and HOURS of AVAILABILITY: (Check all that apply)**

<b>Mornings:</b>	<input type="radio"/> Select All	<input type="radio"/> Mon	<input type="radio"/> Tues	<input type="radio"/> Wed	<input type="radio"/> Thurs	<input type="radio"/> Fri	<input type="radio"/> Sat	<input type="radio"/> Sun
<b>Afternoons:</b>	<input type="radio"/> Select All	<input type="radio"/> Mon	<input type="radio"/> Tues	<input type="radio"/> Wed	<input type="radio"/> Thurs	<input type="radio"/> Fri	<input type="radio"/> Sat	<input type="radio"/> Sun
<b>Evenings:</b>	<input type="radio"/> Select All	<input type="radio"/> Mon	<input type="radio"/> Tues	<input type="radio"/> Wed	<input type="radio"/> Thurs	<input type="radio"/> Fri	<input type="radio"/> Sat	<input type="radio"/> Sun
<b>Overnight:</b>	<input type="radio"/> Select All	<input type="radio"/> Mon	<input type="radio"/> Tues	<input type="radio"/> Wed	<input type="radio"/> Thurs	<input type="radio"/> Fri	<input type="radio"/> Sat	<input type="radio"/> Sun
<b>Number of hours you would like to work:</b>		<input style="width: 50px; height: 20px;" type="text"/> Check ONE = <u>per week</u> <u>per month</u>						
<b>IP CHARACTERISICS</b>					<b>CONSUMER PREFERENCES</b>			
<b>Do you smoke?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Work for a smoker?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Form of transportation?</b>	<input type="checkbox"/> Bus/Transit <input type="checkbox"/> Car		<b>Work with Diabetic Client?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Read/Write English?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Client preference:</b>		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Either			
<b>Will you use a car?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Drive client's vehicle?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Provide Transfer?</b>	Car Equipped with Ramp		<b>Work for clients w/ pets?</b>		Birds <input type="checkbox"/> Yes <input type="checkbox"/> No			
Hoyer Lift <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				Cats <input type="checkbox"/> Yes <input type="checkbox"/> No			
Gait Belt <input type="checkbox"/> Yes <input type="checkbox"/> No	Can Transfer Obese Clients				Dogs <input type="checkbox"/> Yes <input type="checkbox"/> No			
Pivot <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				Reptiles <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Willing to work:</b> <input type="checkbox"/> Holidays <input type="checkbox"/> Live-In Assignment <input type="checkbox"/> On-Call <input type="checkbox"/> Short-Term Respite <input type="checkbox"/> Urgent Care								

## **GEOGRAPHIC PREFERENCE:**

- |                                           |                                      |                                       |
|-------------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Amador City      | <input type="checkbox"/> Fiddletown  | <input type="checkbox"/> Pine Grove   |
| <input type="checkbox"/> Bonnefoy         | <input type="checkbox"/> Ione        | <input type="checkbox"/> Pioneer      |
| <input type="checkbox"/> Buena Vista      | <input type="checkbox"/> Jackson     | <input type="checkbox"/> Plymouth     |
| <input type="checkbox"/> Camanche Village | <input type="checkbox"/> Latrobe     | <input type="checkbox"/> River Pines  |
| <input type="checkbox"/> Clinton          | <input type="checkbox"/> Martell     | <input type="checkbox"/> Sutter Creek |
| <input type="checkbox"/> Drytown          | <input type="checkbox"/> New Chicago | <input type="checkbox"/> Volcano      |

## **TYPE of WORK DESIRED: (Work that you are willing to perform)**

- Select ALL**
- Domestic Services (Clean floors, wash kitchen counters, stoves, refrigerators, bathroom; store food, supplies; take out garbage; dust, pick-up; bring in fuel; change or make bed; and miscellaneous.)
- Preparation of Meals
- Meal Clean-up
- Laundry
- Shopping for Food
- Other Shopping & Errands
- Respiration
- Bowel/Bladder Care (external appliances only)
- Feeding
- Routine Bed-baths
- Dressing
- Menstrual Care
- Ambulation (assisting with walking, or with moving from place to place)
- Transfer
- Bathing/Oral Hygiene/Grooming (includes "stand-by assistance")
- Rubbing Skin; Re-positioning; etc.
- Care & Assistance w/ Prosthesis; Medication set-up (assistance w/ medications)
- Accompaniment to Medical Appointments
- Accompaniment to Alternative Resources
- Protective Supervision (keeping Consumers safe from harming themselves or others)
- Paramedical Services (must have proof of training for specified needs)
- Heavy Cleaning\* (authorized 1x/mo. only)
- Yard Hazard Abatement (if authorized)
- Removal of Snow, Ice (if authorized)
- Teaching & Demonstration

## **WILLING to WORK WITH: (Individuals that you are willing to work with)**

- Select ALL**
- Adults With Developmental Disabilities: Autism, Epilepsy, Brain Injury, etc.
- Adults With Physical Disabilities
- Alzheimer's or Dementia
- Blind/Vision Impaired
- Children With Developmental Disabilities: Autism, Epilepsy, Brain Injury, etc.
- Children With Physical Disabilities
- Contagious Disease (Infectious Disease or Communicable Disease)
- Elderly
- Hospice Care
- Memory Problems
- Mental Health Issues: Bi-Polar, Hoarding, OCD, etc.
- Quadriplegic
- Scent Free
- Speech Impairment/Unable to Speak

**YOUR ETHNICITY: (Optional)**

- |                                                 |                                    |                                          |
|-------------------------------------------------|------------------------------------|------------------------------------------|
| <input type="checkbox"/> African-American       | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Latino    | <input type="checkbox"/> OTHER           |

**LANGUAGES:**

- |                                        |                                   |                                |
|----------------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> American Sign | <input type="checkbox"/> Italian  | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> Arabic        | <input type="checkbox"/> Japanese | [Please specify]               |
| <input type="checkbox"/> English       | <input type="checkbox"/> Spanish  | _____                          |
| <input type="checkbox"/> French        | <input type="checkbox"/> Tagalog  | _____                          |
| <input type="checkbox"/> German        |                                   |                                |

**PRIMARY LANGUAGE: (Pls. identify)**

- ENGLISH
- OTHER (please specify): \_\_\_\_\_

**Do you have any criminal convictions?**

- Yes       No

If "YES", convicted of: \_\_\_\_\_

Conviction date/s: \_\_\_\_\_

Case disposition: \_\_\_\_\_

**Have you ever been arrested for DUI or use of illegal drugs?**

- YES       NO

If "yes", please explain: \_\_\_\_\_

- I have had drug and alcohol problems:

Please explain: \_\_\_\_\_

**Do you give the Registry permission to conduct a background check?**

- YES       NO

**TRAININGS and CERTIFICATIONS**

List any training you have had related to care-giving or in-home care:

List any certificates or licenses you possess:

- |                                    |                         |                              |                         |
|------------------------------------|-------------------------|------------------------------|-------------------------|
| <input type="checkbox"/> First Aid | Expires: ____/____/____ | <input type="checkbox"/> CNA | Expires: ____/____/____ |
| <input type="checkbox"/> CPR       | Expires: ____/____/____ | <input type="checkbox"/> MA  | Expires: ____/____/____ |

How many years of experience providing in-home care do you have?

**REFERENCES**

**Provide a minimum of 2 references. Do not use relatives, please.**

Attached are a few copies of the Registry Reference Form and two return envelopes.

Please give one Registry Reference Form and one return envelope to each of your references

to complete and return to the Public Authority OR your reference may return the envelope to

you to return to the Public Authority.

**Criminal Background Checks on IHSS Providers** - - Current law states, In-Home Supportive Services ("IHSS") Consumers (the employer of IHSS Providers) and the Public Authority:

- Have the legal right to conduct Department of Justice (DOJ) criminal background checks on current Providers or Providers they are considering hiring.
- May decide not to hire or retain Providers who refuse to complete background checks.
- May decide not to hire or retain Providers based on the results of background checks.
- Must protect the confidentiality of the results from DOJ background checks.

I understand that fingerprinting may be done through the Public Authority for the purpose of a DOJ criminal background check. I further understand the results may be shared with my potential employer, the IHSS Consumer.

**I am willing to be fingerprinted for a DOJ background check:**       **YES**       **NO**      **Initials:** \_\_\_\_\_

Further, regarding this application to participate on the Provider-Consumer Registry:

- I certify under penalty of perjury that all the information provided in this application and its related process is true. I understand that any false information may eliminate me from eligibility for participation on the Provider-Consumer Registry.
- I understand that my name may be placed on a list to be given to persons who are seeking assistance in their homes, without further notice.
- I understand the Public Authority retains the exclusive right to list, refer with or without comment, suspend, or remove an individual Provider from the Registry.
- I understand that Registry staff will conduct a background check on me using publicly available resources.
- I understand that the information on this questionnaire may also be shared with prospective employers and their advocates without further notice.
- I understand completing this application and being listed on the Registry **does not guarantee me employment.**
- I understand that my employer is **not** Amador County In-Home Supportive Services ("IHSS") **nor** the Amador County IHSS Public Authority. **The IHSS Consumer is my employer.**
- I further understand that an IHSS Consumer-Employer retains the exclusive right to hire, supervise, and terminate my employment with or without cause.
- I understand that I may by written request, ask that my name be deleted from participation on the Provider-Consumer Registry.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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**Remember you are required to check in with Public Authority on a monthly basis.** Reminders will be sent to you. You can receive text, email or both. If you do not check in, you will be ***made inactive*** and your name ***will not*** be referred to IHSS Consumers.