INDEPENDENT PROVIDER APPLICATION

To Join the Public Authority Registry

***** All information on this form is required, including good references - that we can verify*****

First Name:_____ M:_____ Last Name: _____

Email Address:_____

Address _____
Street City Zip Code

Mailing Address (if different)_____

Home Phone No: _____ Cell Phone No: _____

Social Security No:_____ DOB:_____

Gender: M___ F___

Driver's License No. or CA ID: _____ Expiration Date:_____

Are You Willing To Work With These Special Requirements?		
Yes	No	**Adult With Developmental Disabilities: Autism, Brain Injury, Cerebral Palsy, Epilepsy, etc.**
Yes	No	**Adult With Physical Disabilities**
Yes	No	**Clients With Dementia or Alzheimer's**
Yes	No	**Clients Who Are Vision Impaired or Blind**
Yes	No	**Child/Minor With Developmental Disabilities: Autism, Brain Injury, Cerebral Palsy, etc.**
Yes	No	**Child/Minor With Physical Disabilities**
Yes	No	**Clients Who Are Hearing Impaired or Deaf**
Yes	No	**Clients That Are Elderly**
Yes	No	**Clients Who Have Hospice Care**
Yes	No	**Clients That Have Memory Problems**
Yes	No	**Clients With Mental Health Issues: Bi-Polar, Hoarding, Depression, Schizophrenia, etc.**
Yes	No	**Clients Who Are Quadriplegic (unable to use arms and/or legs)**
Yes	No	**Clients with Allergies, must be scent-free (no perfume, scent - free soaps & lotions)**
Yes	No	**Clients Who Smoke Inside and Outside**
Yes	No	**Clients Who Smoke Outside Only**
Yes	No	**Clients Who Have A Speech Impairment or Unable to Speak**

Tell Us More About Yourself:		
Yes	No	**Do You Have A Car You Are Willing To Use To Transport Client In?**
Yes	No	**Do You Smoke?**
Yes	No	**If "YES", are you willing to not smoke at work?**
Yes	No	**Will You Work Holidays?**
Yes	No	**Will You Work as On-Call Urgent Care?**
Yes	No	**Will You Work for Short-Term Assignments?**
Yes	No	**Will You do Transfers with a Gait Belt?**
Yes	No	**Will You do Transfers with a Hoyer Lift?**
Yes	No	**Will You do a Pivot Transfer?**
Yes	No	**Will You do Transfers using a Sliding Board?**
Yes	No	**Will You Work With Diabetics?**

1. What is your <u>MAIN</u> form of transportation? Bus___ Car___ Other_____

2. Are you willing to transport clients to and from doctor appointments? Yes____ No____
(You must have your own car, valid driver's license, and auto insurance.)

3. What is your client preference? Male ___ Female ___ Either___

4. Will you work around pets? Yes___ No___ **If yes,** Cats___ Dogs___ Birds___ Reptiles ___

5. Language (s) spoken fluently: _____**Other:** _____

6. Number of years of In-Home care experience: _____

7. How did you hear about us? _____

Check Areas That You Will Accept Work.							
☐	Calpella	☐	Bell Spring	☐	Albion	☐	Manchester
☐	Boonville	☐	Branscomb	☐	Anchor Bay	☐	Mendocino
☐	Hopland	☐	Brooktrails	☐	Camp Noyo	☐	Navarro
☐	Potter Valley	☐	Covelo	☐	Caspar	☐	Newport
☐	Redwood Valley	☐	DeCamp	☐	Cleone	☐	Northspur
☐	Talmage	☐	Dos Rios	☐	Comptche	☐	Noyo
☐	Ukiah	☐	Laytonville	☐	DeHaven	☐	Philo
☐	Yorkville	☐	Leggett	☐	Elk	☐	Point Arena
☐		☐	Piercy	☐	Fort Bragg	☐	Rockport
☐		☐	South Leggett	☐	Gualala	☐	South Fork
☐		☐	Willits	☐	Little River	☐	Westport
☐		☐		☐		☐	

Tasks willing to complete:		
Yes	No	**Domestic Services (cleaning, sweeping, vacuuming, etc.)**
Yes	No	**Cooking Meals**
Yes	No	**Cleaning-up after Meals**
Yes	No	**Laundry**
Yes	No	**Shopping for Food**
Yes	No	**Other Shopping/Errands**
Yes	No	**Respiration (assisting client with Home Oxygen, CPAP, Nebulizer etc.)**
Yes	No	**Bowel & Bladder Care (discuss with client; some only need supplies stocked)**
Yes	No	**Feeding (mealtime assistance)**
Yes	No	**Routine Bed Baths**
Yes	No	**Dressing**
Yes	No	**Menstrual Care**
Yes	No	**Ambulation (walking assistance - with cane, walker and/or wheelchair)**
Yes	No	**Transfer (transferring the client from bed to wheelchair; helping up from chair.)**
Yes	No	**Bathing, Grooming and Oral Hygiene (remind, help or assist with shaving, brushing teeth, etc.)**
Yes	No	**Rubbing Skin, Repositioning**
Yes	No	**Care & Assistance with Prosthesis (Medication Reminders and/or Prosthesis)**
Yes	No	**Accompany Client to Medical Appointments**
Yes	No	**Accompany Client to Alternative Resources**
Yes	No	**Protective Supervision**
Yes	No	**Paramedical Services – Invasive Care (such as Insulin injections, wound care, etc)** *(Client/Doctor or Nurse will train)*
Yes	No	**Heavy Cleaning –** *(Prior Authorization from Social Worker Required)*

DAYS AND HOURS OF AVAILABILITY/WILLING TO WORK: (Check all that apply)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8 AM - 10 AM							
10 AM - 12 PM							
12 PM - 2 PM							
2 PM - 4 PM							
4 PM - 6 PM							
6 PM - 8 PM							

HOURS PER WEEK YOU WOULD LIKE TO WORK (Not over 66 hours):

Number of Hours:_____

List any training (and date of training) you have had related to In-Home care. **Please include any training you attended through Public Authority Services:**

_____

_____

LIST ANY CERTIFICATES OR LICENSES YOU POSSESS: (Please use extra sheet if necessary)

_____

Certificate License | Institution | Expiration Date

_____

Certificate License | Institution | Expiration Date

WORK AND PERSONAL REFERENCE INFORMATION BELOW MUST BE COMPLETE

(Please use extra sheet if necessary)

LIST YOUR WORK REFERENCES INFORMATION. *You must provide 2 positive work references (can be co-workers or volunteer work), from within the last 3 years.*
MAKE SURE THAT YOU PROVIDE WORKING PHONE *NUMBERS,* *(because we will contact your references).*

WORK REFERENCE #1:

EMPLOYED FROM: _____ (Month/Year) TO: _____ (Month/Year) HOURS WORKED PER WEEK _____

CLIENT OR COMPANY NAME: _____

PHONE NO.: _____

NAME OF SUPERVISOR: _____ PHONE NO.: _____ (Area Code Required)

JOB TITLE AND DUTIES: _____

_____

_____

WORK REFERENCE #2:

EMPLOYED FROM: _____ (Month/Year) TO: _____ (Month/Year) HOURS WORKED PER WEEK _____

CLIENT OR COMPANY NAME: _____

PHONE NO.: _____

NAME OF SUPERVISOR: _____ PHONE NO.: _____ (Area Code Required)

JOB TITLE AND DUTIES: _____

_____

_____

Personal Reference:

Name: _____ Relationship: _____

Phone No: _____ Years Known: _____

HAVE YOU EVER BEEN CONVICTED BY ANY COURT OF A CRIME? Yes___ No___

If Yes; please explain: _____

_____

_____

I declare that all information provided is correct and true. I understand that misrepresentation or omission of facts called for is cause for removal from the Public Authority Registry.

_____ _____

Signature of Applicant **Date**

INCOMPLETE APPLICATIONS WILL BE RETURNED AND/OR DENIED

'As a referral service, the Public Authority Registry retains the exclusive right to exercise discretion in its selection of Providers. The Registry operates as an optional and non-compulsory service to match IHSS providers with consumers. All providers may work for any consenting IHSS consumer without being a part of the Registry. Removal or rejection from the Registry does not preclude an individual from working as an IHSS provider, nor does being on the Registry guarantee that we will find work for you.'