

# PROVIDER REGISTRY APPLICATION

IHSS PUBLIC AUTHORITY

Office Use Only	
Coordinates Grid: _____	Page: _____
Verified ID: _____	
Interviewed: ____/____/____	
By: _____	

### APPLICANT INFORMATION

Use ink, PRINT clearly, and answer ALL questions.

Applicant Name: \_\_\_\_\_  
Last First Middle Initial

List all other names used: \_\_\_\_\_

Residential Address: \_\_\_\_\_  
Street City/State Zip

Mailing Address: \_\_\_\_\_  
Street City/State Zip

Phone # 1: \_\_\_\_\_  Home  Cell Other: \_\_\_\_\_

Phone # 2: \_\_\_\_\_  Home  Cell Other: \_\_\_\_\_

ID Type: \_\_\_\_\_ Number: \_\_\_\_\_ Exp: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### ETHNICITY

(statistical purposes only)

- |  |  |                                   |                                       |                                     |
|--|--|-----------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Caucasian                 | <input type="checkbox"/> Native American | <input type="checkbox"/> Japanese | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Laotian    |
| <input type="checkbox"/> Hispanic                  | <input type="checkbox"/> Filipino        | <input type="checkbox"/> Korean   | <input type="checkbox"/> Hawaiian     | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> African American          | <input type="checkbox"/> Chinese         | <input type="checkbox"/> Samoan   | <input type="checkbox"/> Guamanian    | <input type="checkbox"/> Other      |
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> Cambodian       |                                   |                                       |                                     |

### LANGUAGE SKILLS

I speak English:  Yes  No  Limited Preferred Language: \_\_\_\_\_

I read English:  Yes  No  Limited Any other language you read? \_\_\_\_\_

I write English:  Yes  No  Limited Any other language you write? \_\_\_\_\_

Check any other language you speak well enough to provide care:

- |  |                                  |                                 |                                   |                                     |                                     |
|--|----------------------------------|---------------------------------|-----------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> American Sign | <input type="checkbox"/> Chinese | <input type="checkbox"/> Farsi  | <input type="checkbox"/> Italian  | <input type="checkbox"/> Mandarin   | <input type="checkbox"/> Spanish    |
| <input type="checkbox"/> Arabic        | <input type="checkbox"/> English | <input type="checkbox"/> French | <input type="checkbox"/> Japanese | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Tagalog    |
| <input type="checkbox"/> Cantonese     | <input type="checkbox"/> Eitrian | <input type="checkbox"/> German | <input type="checkbox"/> Korean   | <input type="checkbox"/> Russian    | <input type="checkbox"/> Vietnamese |

### ENVIRONMENT

Smoking:  I smoke (If you smoke, you must smoke outside during work hours – never in a clients' home.)

I am willing to work for a client who smokes:  inside  outside  I will not work for a smoker

Pets: Willing to work around pets?  Yes  No

### ACCESSIBILITY/TRANSPORTATION

Form of transportation:  Bus  \*Personal vehicle  Other: \_\_\_\_\_

\*If you marked "personal vehicle", are you willing to use it to transport clients and/or complete related tasks?  Yes  No

### GEOGRAPHIC PREFERENCE

(Please check the areas where you are willing to work.)

- |                                      |                                     |                                     |  |   |
|--------------------------------------|-------------------------------------|-------------------------------------|--|---|
| <input type="checkbox"/> Ballard     | <input type="checkbox"/> Goleta     | <input type="checkbox"/> Los Olivos | <input type="checkbox"/> Santa Barbara | <input type="checkbox"/> Solvang            |
| <input type="checkbox"/> Buellton    | <input type="checkbox"/> Guadalupe  | <input type="checkbox"/> New Cuyama | <input type="checkbox"/> Santa Maria   | <input type="checkbox"/> Summerland         |
| <input type="checkbox"/> Carpinteria | <input type="checkbox"/> Lompoc     | <input type="checkbox"/> Orcutt     | <input type="checkbox"/> Santa Ynez    | <input type="checkbox"/> Vandenberg Village |
| <input type="checkbox"/> Casmalia    | <input type="checkbox"/> Los Alamos |                                     |  |   |

**DAYS / HOURS AVAILABLE TO WORK**

Schedule Preference Notes: \_\_\_\_\_

- Mornings (before 12:00pm):  Mon  Tue  Wed  Thu  Fri  Sat  Sun
- Afternoons (after 12:00pm):  Mon  Tue  Wed  Thu  Fri  Sat  Sun
- Evenings (after 5:00pm):  Mon  Tue  Wed  Thu  Fri  Sat  Sun

Number of hours per week you would like to work: \_\_\_\_\_

Will you work:  Holidays  On-Call  Overnights  Urgent Need  1-2 Hour Shifts  Live-In

**WILLING TO WORK FOR**

- Children  Women  Persons with Terminal Illnesses
- Elderly  Persons with Developmental Disabilities  Other: \_\_\_\_\_
- Men  Persons with Memory Problems

**TYPE OF WORK WILLING TO PERFORM**

<i>Domestic Tasks</i>	<i>Personal Tasks</i>	
<input type="checkbox"/> Accompany to Medical Appointments	<input type="checkbox"/> Ambulating	<input type="checkbox"/> Dressing
<input type="checkbox"/> Domestic Services	<input type="checkbox"/> Bathing – Female	<input type="checkbox"/> Feeding
<input type="checkbox"/> Heavy Cleaning	<input type="checkbox"/> Bathing – Male	<input type="checkbox"/> Lifting/Transferring
<input type="checkbox"/> Laundry	<input type="checkbox"/> Bathing Assistance	<input type="checkbox"/> Menstrual Care
<input type="checkbox"/> Meal Clean Up	<input type="checkbox"/> Bed Bathing	<input type="checkbox"/> Paramedical Services
<input type="checkbox"/> Other Shopping & Errands	<input type="checkbox"/> Bowel & Bladder Care	<input type="checkbox"/> Respiratory Assist
<input type="checkbox"/> Preparation of Meals	<input type="checkbox"/> Care & Assist w/Prosthesis	<input type="checkbox"/> Rubbing Skin/Repositioning
<input type="checkbox"/> Protective Supervision		
<input type="checkbox"/> Shopping For Food		

**TRAINING AND CERTIFICATION**

We will need to see your original certificate(s)

First Aid: \_\_\_\_\_ Expiration Date \_\_\_\_\_  CHHA: \_\_\_\_\_ Expiration Date \_\_\_\_\_ How many years of experience providing in-home care do you have? \_\_\_\_\_

CPR: \_\_\_\_\_  CAN: \_\_\_\_\_

Other: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

**BACKGROUND INFORMATION**

Have you been convicted of a felony and/or misdemeanor charge, or been on parole or probation?  Yes  No

**If Yes, list all convictions since your 18<sup>th</sup> birthday. List offense date and place of conviction, sentence and date of release from custody and/or from probation/parole, and other facts you want considered. A Yes answer to this question is not an automatic bar to being on the Provider Registry. Each case is considered individually.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you give the Provider Registry permission to conduct a background check?  Yes  No

**REFERENCES**

**Application may be denied if this section is not completed.**

**WORK HISTORY** Please list most recent employment first (PLEASE NOTE: IHSS RECIPIENT IS THE EMPLOYER, NOT IHSS).

*If you do not have work references, please provide other references such as volunteer experience, baby-sitting, etc.*

From:	Month	Year	Employer (Business or Client's Name):	Job Title:	
To:	Month	Year	Mailing Address: Street / City / State / Zip Code		
Name of supervisor:			Employer's Phone Number: ( )	Reason for leaving:	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
From:	Month	Year	Employer (Business or Client's Name):	Job Title:	
To:	Month	Year	Mailing Address: Street / City / State / Zip Code		
Name of supervisor:			Employer's Phone Number: ( )	Reason for leaving:	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
From:	Month	Year	Employer (Business or Client's Name):	Job Title:	
To:	Month	Year	Mailing Address: Street / City / State / Zip Code		
Name of supervisor:			Employer's Phone Number: ( )	Reason for leaving:	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No

**PERSONAL REFERENCES**

List three people you know personally, whom we can contact as references. **Do not list family members.**

Name:	Home Phone: ( )	Other Contact #: ( )
Mailing Address: Street / City / State / Zip Code	Can be reached during business hours? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to applicant?	How long have you known this person?	
Name:	Home Phone: ( )	Other Contact #: ( )
Mailing Address: Street / City / State / Zip Code	Can be reached during business hours? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to applicant?	How long have you known this person?	
Name:	Home Phone: ( )	Other Contact #: ( )
Mailing Address: Street / City / State / Zip Code	Can be reached during business hours? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to applicant?	How long have you known this person?	

