PUBLIC AUTHORITY
IN-HOME SUPPORTIVE SERVICES
MARIN COUNTY

PA Marin Registry Provider Application

Name: (First) _____ (Middle) _____ (Last) _____

Email Address _____

Address _____

Mailing Address (if different) _____

Home Phone No._____ Mobile Phone No _____

Do you authorize the Public Authority to communicate to you via text?

Yes_____ No_____

(Msg & Data rates may apply)

Social Security No _____ Date of Birth_____

Gender: Male_____ Female_____ Other _____

Do you have a Valid CA Driver's License? Yes_____ No_____

If yes, what is the number? _____Expiration Date_____

State ID Number (if applicable) _____

Disclaimer: Not having a valid CA Driver's License won't disqualify you to be part of the PA Marin Registry. However, you must notify your recipient about your inability to drive.

DAYS AND HOURS OF AVAILABILITY: (Check all that apply)

Mornings: Mon____ Tues____ Wed ____ Thurs____ Fri____ Sat____ Sun _____

Afternoons: Mon____ Tues____ Wed ____ Thurs____ Fri____ Sat____ Sun _____

Evenings: Mon____ Tues____ Wed ____ Thurs____ Fri____ Sat____ Sun _____

NUMBER OF HOURS PER WEEK YOU WOULD LIKE TO WORK: _____

PLEASE TELL US ABOUT YOURSELF

1. Do you have experience as a home-caregiver? Yes_____ No_____
   If yes, how many years? _____

2. Can you work short-term assignments? Yes ____ No____

3. Can you work as on-call urgent care? Yes ____ No____

4. Are you willing to work in a live-in position? Yes ____ No_____

5. What is your MAIN form of transportation? Car ____ Bus_____ Walk ____

6. Are you a smoker? Yes ____ No_____

7. What is your client preference? Male_____ Female_____ Either_____

8. Will you work around pets? Yes ____ No_____

   If Yes, Cats_____ Dogs_____ Birds_____ Reptiles_____ Any pets_____

9. Language(s) spoken frequently: _____ Other: _____

ARE THERE ANY AREAS IN MARIN COUNTY WHERE <u>YOU DO NOT WANT TO WORK</u> AT?

Please list them here: _____

RECIPIENTS THAT YOU ARE WILLING TO WORK FOR: (Please mark with an "X" on all that apply)

1. Yes ____ No____ Adults with developmental disabilities: (autism, cerebral palsy, epilepsy, etc.).

2. Yes ____ No____ Adults with physical disabilities.

3. Yes ____ No____ Clients with Alzheimer's or Dementia.

4. Yes ____ No____ Clients with visual impairments and blind.

5. Yes ____ No____ Children/ Minor with developmental disabilities: (autism, cerebral palsy, epilepsy, etc.).

6. Yes ____ No____ Children with physical disabilities.

7. Yes ____ No____ Clients with hearing impairments and deaf.

8. Yes ____ No____ Elderly individuals.

9. Yes ____ No____ Recipients under Hospice Care.

10. Yes ____ No____ Recipients with memory problems.

11. Yes ____ No____ Clients with mental health issues (Schizophrenia, Bi-Polar, hoarders, depression, etc.).

12. Yes ____ No____ Work for clients with severe allergies and need to be scent free (no perfume; using scent free soaps and lotions etc.).

13. Yes ____ No____ Clients who are quadriplegic

14. Yes ____ No____ Smokers.

15. Yes ____ No____ Clients with communication impairments (speech impairments, unable to speak).

16. Yes ____ No____ Recipients with diabetes.

TYPE OF WORK YOU ARE WILLING TO DO

1. Yes ____ No____ Domestic services (cleaning, sweeping, vacuuming, meal prep, shopping, laundry, etc.).

2. Yes ____ No____ Respiration.

3. Yes ____ No____ Assistance with bowel and bladder care, and toileting needs.

4. Yes ____ No____ Personal Care (bathing, feeding, dressing, grooming, and oral hygiene)

5. Yes ____ No____ Assistance with bed baths

6. Yes ____ No____ Assistance with menstrual care

7. Yes ____ No____ Ambulation

8. Yes ____ No____ Transferring Clients. If yes, select method of transfer:

   Hoyer Lift _____ Sliding Board_____ Pivot Transfer _____ Gait Belt _____

9. Yes ____ No____ Rub skin, repositioning, and range of motion (light exercises)

10. Yes ____ No____ Care and assistance w/ prostheses (help putting on/taking off, maintaining and cleaning and artificial limb and medication reminders)

11. Yes ____ No____ Transportation to and from medical appointments (you must have your own car, valid driver's license and auto insurance)

12. Yes ____ No____ Protective Supervision (take care of recipients that can't be left alone).

13. Yes ____ No____ Paramedical Services

14. Yes ____ No____ Heavy Cleaning

15. Yes ____ No____ Teaching and Demonstration

PLEASE TELL US ABOUT YOUR BACKGROUND

Have you ever completed the state mandated IHSS Enrollment Process, including finger prints?

Yes ____ No____ Not Sure____

If yes, how long ago? _____

List any training (and date of training) you have had related to in home care:

_____

_____

_____

List any certificates or licenses you possess (Current or expired, even from other countries)

_____

_____

Any additional skills that you would like us to be aware of?

_____

_____

LIST YOUR WORK REFERENCES BELOW, YOU MUST PROVIDE AT LEAST 3 VERIFIABLE REFERENCES. MAKE SURE THAT YOU PROVIDE WORKING PHONE NUMBERS.

WORK REFERENCE #1:

Employed From: _____ To: _____ Phone Number: _____

Client Name or Company Name: _____

Job Title and Duties: _____

_____

_____

WORK REFERENCE #2:

Employed From: _____ To: _____ Phone Number: _____

Client Name or Company Name: _____

Job Title and Duties: _____

_____

_____

WORK REFERENCE #3:

Employed From: _____ To: _____ Phone Number: _____

Client Name or Company Name: _____

Job Title and Duties: _____

_____

_____

Have you ever been convicted of a felony or misdemeanor charge, or been on parole of probation?
Yes_____ No _____

Explain if the answer was YES: _____

_____

_____

Who should we contact in case of an emergency?

Name: _____ Relationship: _____

Phone number: _____

I declare to my knowledge that all information provided is correct and true. I understand that misrepresentation or omission of facts called for is cause for unacceptance and or removal from the IHSS Public Authority Registry. Removal from the IHSS Public Authority of Marin Registry does not prevent an individual from working as an IHSS provider.

_____

Applicant Signature Date

FOR OFFICE USE ONLY:

NOTES:

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PROVIDER ENROLLMENT AGREEMENT

I, the undersigned provider, understand and agree to (Please initial each line):

_____ Be on time to work and for interviews. Be kind, polite and professional at all times.

_____Call the consumer as soon as possible if I will be late or cannot work at the agreed schedule

_____Provide reliable, safe, high quality services as directed by the consumer and authorized by the social worker.

_____Work the agreed number of days and hours.

_____Maintain confidentiality about the consumer's personal and private affairs with anyone other than IHSS social workers or Registry staff.

_____Be paid twice a month, after the time sheet has been correctly filled out, signed by both the provider and consumer, and has been submitted to IHSS.

_____Inform the Registry of changes in address, phone numbers, preferences and hours available. Call the Registry at least once a month to confirm continued availability.

_____Report suspected abuse of dependent elderly or disabled persons to Adult Protective Services (415-473-2774).

_____Request the assistance of IHSS Public Authority of Marin if either provider or consumer is having difficulty working with the other.

_____I authorize the Public Authority of Marin to disclose to prospective employers and their social workers, when asked, information learned as a result of my background checks.

_____I understand that the current wage is _____ per hour and that I will not claim hours that I did not actually work. I understand it is criminal fraud to sign a timesheet that has false information.

_____I will not perform tasks that are not authorized by the County and claim IHSS time for them.

_____I will not ask for wage supplementation. I understand that failure to comply with this provision is cause for removal from the Registry.

_____

Provider's Name (Print) Provider's Signature Date

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MANDATED REPORTING OF ELDER AND DEPENDENT ADULT ABUSE (WELFARE AND INSTITUTIONS CODE 15630)

STATEMENT TO BE SIGNED BY IN HOME CARE PROVIDERS

I understand that as an IHSS Care Provider, I must report any known or suspected incidence of abuse of an elder or dependent adult to the Marin Adult Protective Services by calling 415-473-2774 immediately or as soon as possible. I understand that abuse includes the following:

- ✓ Physical Abuse
- ✓ Emotional Abuse
- ✓ Neglect/Abandonment
- ✓ Financial Abuse
- ✓ Isolation
- ✓ Abduction/Kidnapping

I also understand that failure to report such abuse is punishable by law.

Name: _____ (Please Print)

Signature: _____ Date: _____