



Registry Application Independent Provider (IP)

First Name:	Middle Initial:
Last Name:	Email:
Home Phone:	Cell Phone: Message Phone:
Mailing Address:	City: Zip Code:
Drivers License:	Exp Date:
Proof of Current Auto Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Exp Date:

Days and Hours of Availability: (Check all that apply)

Mornings:	<input type="checkbox"/> Select All	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat	<input type="checkbox"/> Sun
Afternoons:	<input type="checkbox"/> Select All	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat	<input type="checkbox"/> Sun
Evenings:	<input type="checkbox"/> Select All	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat	<input type="checkbox"/> Sun
Overnight:	<input type="checkbox"/> Select All	<input type="checkbox"/> Mon	<input type="checkbox"/> Tues	<input type="checkbox"/> Wed	<input type="checkbox"/> Thurs	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat	<input type="checkbox"/> Sun
Number of hours you would like to work per week _____								
Are you looking for a Live-In position? <input type="checkbox"/> Yes <input type="checkbox"/> No								

About You	Consumer Characteristics
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will you work for a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No
How will you get to work?: <input type="checkbox"/> Bus <input type="checkbox"/> Car	Do you have a preference who you work for? If yes please indicate. <input type="checkbox"/> Male <input type="checkbox"/> Female
Do you read and write English? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will you drive a Consumer's car for authorized tasks? <input type="checkbox"/> Yes <input type="checkbox"/> No
Will you use your car for authorized tasks? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will you work with pets in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No

Geographic Preference

Sierra County	Plumas County	
<input type="checkbox"/> Calpine	<input type="checkbox"/> Belden	<input type="checkbox"/> Lake Almanor
<input type="checkbox"/> Downieville	<input type="checkbox"/> Canyon Dam	<input type="checkbox"/> Meadow Valley
<input type="checkbox"/> Loyalton	<input type="checkbox"/> Chester	<input type="checkbox"/> Mohawk
<input type="checkbox"/> Sierraville	<input type="checkbox"/> Chilcoot	<input type="checkbox"/> Paxton
<input type="checkbox"/> Sierra City	<input type="checkbox"/> Greenville	<input type="checkbox"/> Portola
	<input type="checkbox"/> Clio	<input type="checkbox"/> Quincy
	<input type="checkbox"/> Cromberg	<input type="checkbox"/> Spring Garden
	<input type="checkbox"/> Crescent Mills	<input type="checkbox"/> Taylorsville
	<input type="checkbox"/> East Quincy	<input type="checkbox"/> Vinton
	<input type="checkbox"/> Graeagle	
	<input type="checkbox"/> Johnsville	
	<input type="checkbox"/> Keddie	

Type of Work Desired

- Accompaniment to Medical Resources
- Ambulation (assisting with walking, sitting, in/out cars etc.)
- Bathing - Oral Hygiene - Grooming
- Bowel & Bladder Care: Full Care
- Bowel & Bladder Care: Minimal Assistance
- Care & Assistance with Prosthesis (cane, walkers, wheelchairs, back brace, etc.)
- Consumer uses Oxygen
- Domestic Services (basic housecleaning duties)
- Dressing
- Feeding (cutting up food, prompting to eat, assisting with eating)
- Heavy Cleaning (authorized by IHSS social worker)
- Meal Clean Up (dishes, wiping down counters, etc.)
- Menstrual Care (changing pads, etc.)
- Moving In/Out of Bed
- Other Shopping & Errands
- Paramedical Services (assisting w/ ace bandages, Band-Aids, med stockings, etc)
- Preparation of Meals
- Protective Supervision (supervising an adult or child who can't be left unattended)
- Respiration (assisting w/ breathing treatments etc.)
- Routine Bed Baths
- Routine Laundry
- Rubbing Skin - Repositioning - Etc.
- Shopping for food

Willing to work with:

- Adults
- Children
- Development Disability
- Elderly
- Memory Problems
- Men
- Terminal Illness
- Women

Languages Spoken

<input type="checkbox"/> American Sign	<input type="checkbox"/> English	<input type="checkbox"/> French	<input type="checkbox"/> German	<input type="checkbox"/> Russian
<input type="checkbox"/> Spanish	<input type="checkbox"/> Other			

Applicant Ethnicity (Optional)

<input type="checkbox"/> African American
<input type="checkbox"/> Asian
<input type="checkbox"/> Caucasian
<input type="checkbox"/> Latino
<input type="checkbox"/> Native American
<input type="checkbox"/> Other

List any training or experience you have had related to In-Home care:

List any certificates or licenses you possess: (Copies of certificates need to be attached)

<input type="checkbox"/> First Aid	<input type="checkbox"/> Expires:	<input type="checkbox"/> Expired
<input type="checkbox"/> CPR	<input type="checkbox"/> Expires:	<input type="checkbox"/> Expired
<input type="checkbox"/> CNA	<input type="checkbox"/> Expires:	<input type="checkbox"/> Expired
<input type="checkbox"/> CHHA	<input type="checkbox"/> Expires:	<input type="checkbox"/> Expired

Please explain why you are interested in In-Home care:

How did you hear about us?		<input type="checkbox"/> Newspaper	<input type="checkbox"/> Radio/TV	<input type="checkbox"/> Word of Mouth
<input type="checkbox"/> IHSS Social Worker	<input type="checkbox"/> EDD/CALWorks	<input type="checkbox"/> CUHW Union	<input type="checkbox"/> IHSS Provider	<input type="checkbox"/> Other
<input type="checkbox"/> Church	<input type="checkbox"/> Flyer	<input type="checkbox"/> Training	<input type="checkbox"/> Phonebook	
<input type="checkbox"/> Independent Living Center	<input type="checkbox"/> Public Authority Website			

I certify under penalty of perjury that all information on this form is true and correct to the best of my knowledge. I understand that any omission or misrepresentation of information on this form may disqualify me from being listed on the Registry. I give the Public Authority permission to share relevant information in my file with individual consumers who are looking for providers. I understand that any false information may eliminate me from eligibility for participation on the Public Authority Registry.

I understand and give permission with regard to the above paragraph.

Signature

Date