PUBLIC AUTHORITY
IN-HOME SUPPORTIVE SERVICES
MARIN COUNTY

PA Marin Registry Provider Application

Date: ____________________

How did you hear about us? ____________________

Your full name: ____

Social Security #: ____________________________ Date of birth: _________________________________

Sex: ☐ Man ☐ Woman Gender: ☐Male ☐Female ☐Other ☐ Declined to answer

Home address: ____

Mailing address (if applicable) ____

Land phone number: ______________________________ cell #: ___________________________________

Email address: ____

Do you authorize Public Authority to send you text messages? ☐ Yes ☐ No

(Message and data rates may apply)

Driver license #: ______________________________________ Expiration date: _____________________

State ID # (if applicable): _______________________________ ☐Expiration date: ___________________

DISCLAIMER: Not having a valid driver's license will not disqualify you from being a part of the PA Marin Registry. However, you must notify your client about your inability to drive.

DAYS AND HOUR SOF AVAILABILITY: (Check all that apply):

Morning: Mon____ Tue____ Wed ____ Thu____ Fri____ Sat____ Sun _____

Afternoon: Mon____ Tue____ Wed ____ Thu____ Fri____ Sat____ Sun _____

Evening: Mon____ Tue____ Wed ____ Thu____ Fri____ Sat____ Sun _____

NUMBER OF HOURS PER WEEK THAT 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 ☐Walking

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) you speak fluently:____

Please list the areas in Marin County where you **DO NOT WANT** TO WORK AT?

____

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 COVID-19
8. ☐Yes ☐No Clients with hearing impairments and deaf.

9. ☐Yes ☐No Individuals 65 and older

10. ☐Yes ☐No Clients under Hospice Care.

11. ☐Yes ☐No Clients with memory problems.

12. ☐Yes ☐No Clients with mental health issues (Schizophrenia, Bi-Polar, hoarders, depression, etc.).

13. ☐Yes ☐No Work for clients with severe allergies and need to be scent free (no perfume, only scent free soaps and lotions etc.).

14. ☐Yes ☐No Clients who are quadriplegic.

15. ☐Yes ☐No Smokers.

16. ☐Yes ☐No Clients with communication impairments (speech impairments, unable to speak).

17. ☐Yes ☐No Clients 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 Assist with machine/bottle of oxygen.

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 cannot 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 fingerprints?

☐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:

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 always.

_____Call the client 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 client and authorized by the IHSS social worker.

_____Work the agreed number of days and hours.

______Maintain confidentiality about the client's personal and private affairs with anyone other than IHSS social workers or Public Authority Registry staff.

_____Be paid twice a month, after the time sheet has been submitted electronically over the ETS[1] or TTS[2] and approved by the client.

_____Inform Public Authority of changes in address, phone numbers, preferences, and hours available. Respond to the text message from Public Authority at the beginning of each 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 Public Authority if either provider or client is having difficulty working with the other.

_____I authorize Public Authority to disclose to prospective employers and their social workers, when asked, information learned because 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 an electronic 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

[1] (ETS) Electronic Time Sheet
[2] (TTS) Telephone Time Sheet

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: ____________________