

REGISTRY APPLICATION FORM FOR CONSUMERS

First Name:	Last Name:	Middle Initial:
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Complete at least one of the following items:

IHSS Case #: 19- _____

Social security #: _____ - _____ - _____

My telephone number (s): (____) _____ (____) _____

Fax: (____) _____ **E-mail:** _____

My home address: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip:** _____

Gender: Male Female **Date of Birth (optional):** _____

Race/Ethnic Group: (Optional - this information is collected only for statistical reasons. It is not used for matching or assignments.)

Language(s) I speak:

1: _____ **2:** _____ **Other:** _____

List the names and phone numbers of people we can contact in case of an emergency relating to your health.

Emergency Contact 1 : _____ **Emergency Phone #** _____

Emergency Contact 2 : _____ **Emergency Phone #** _____

Please check the IHSS services which the County has authorized for you.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Accompany To
Dr. App't | <input type="checkbox"/> Dressing | <input type="checkbox"/> Other Personal
Care Services | <input type="checkbox"/> Service
Animals |
| <input type="checkbox"/> Ambulation
Exercises | <input type="checkbox"/> Errands | <input type="checkbox"/> Prosthetic
Assistance | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Feeding | <input type="checkbox"/> Protective
Supervision | <input type="checkbox"/> Wheelchair
Assistance |
| <input type="checkbox"/> Bed Baths | <input type="checkbox"/> Grooming | <input type="checkbox"/> Repositioning
and Skin Care | |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Ironing | | |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Laundry | | |
| | <input type="checkbox"/> Medication
Dispensation | | |

If you require a provider with special experience and skills, please specify:

Are you authorized by IHSS to receive paramedical services such as insulin injections, feeding tube assistance, etc.?

Yes No

If "yes", provide details in above box.

If personal care is involved, who are you willing to consider?

Male Female Either

Choose one of the following statements. When receiving Registry referrals:

- please give me the names and phone numbers of applicants so that I can contact them myself.
- please give my name, telephone number, and other information to applicants, so that they may contact me.

Note: For prompt back-up attendant referrals, the Registry will give your name, telephone number, and other information to potential back-up attendants.

Do you require that your provider not use scented fragrances on the job?

Yes No

Some providers have allergies or aversions to household pets.

Do you have a dog? Yes No

Do you have a cat? Yes No

Do you maintain a smoke-free environment in your home?

Yes No

Are you in need of a provider at this time? Yes No

If “No,” PASC will keep your application for future use. Call the Registry when you are in need of a Provider.

Work Schedule: Consumers will have a wider choice of provider applicants if they specify the days and times of day for which they are seeking services. Indicate with a check mark (✓) the days and times of day when you might be willing to schedule services.

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Morning							
Afternoon							
Evening							
Overnight							
Live-in							

I certify that the information I have provided in this initial application is true to the best of my knowledge. I authorize the Registry to obtain additional information from the L.A. County Department of Public Social Services regarding my eligibility for IHSS services and other pertinent data to assist in the referral process.

X _____
Consumer's Signature

Date

Note:

If consumer was assisted in completing this application, print below the name and telephone number of the person who assisted.

Name of person who assisted consumer

Telephone number

***PASC Homecare Registry
4730 Woodman Ave., Ste 405
Sherman Oaks, CA 91423***

***Toll Free: (877) 565-4477
TTY: (818) 206-7015
FAX: (818) 206-8000***

FOR OFFICE USE ONLY

IHSS Consumer's Rights, Responsibilities and Release Form completed?

Yes No

Date Processed: _____ **By:** _____

Approved for Registry? Yes No

If no, explain: _____

Approved for Back-Up Attendant Program? Yes No

IHSS Consumers Only!

PASC HOMECARE REGISTRY **IHSS CONSUMER'S SERVICES AND RELEASE AGREEMENT**

If you need assistance in reading or understanding this document, you should obtain the help of a trusted family member, friend or representative.

You intend to use Consumer services of the PASC Homecare Registry. For all enrolled Consumers the Registry provides referrals of regular IHSS homecare Providers. For certain eligible enrolled Consumers the Registry also provides referrals of temporary back-up attendants under the PASC Back-up Attendant Program. **The term "Provider" as used in this Agreement covers both regular Providers and also Back-up Attendants.** As a condition for your use of the services of the Registry, the following matters are acknowledged and agreed upon:

1. **Registry's Limited Role:** PASC operates the Homecare Registry, free of charge to all participants, primarily for the purpose of assisting individual Consumers and Providers to make contact with one another and possibly form an employment relationship. The Registry performs only limited background checks and it does not vouch for the skills or qualities of the Providers it refers.
2. **Consumer is the Employer:** You decide whether to hire any referred Provider, or request another referral. You retain the sole authority to assign duties, supervise, and terminate the Provider. Also, the provision of paramedical services such as insulin injections and feeding tube assistance by any Provider (including back-up attendants) is solely under the authority of you and your physician. **You therefore must use your own judgment and make your own decisions regarding any Provider's skills, character and compatibility, and take charge of the employment relationship. You assume and accept the risk of all employment selection decisions and employer responsibilities. PASC has no responsibility for such matters or for any injuries that may arise out of the referral or the employment.**
3. **Criminal Background Checks:** The Registry requires its Provider applicants to clear a Criminal Background check so that Consumers can be assured that a referred Provider does not have certain disqualifying kinds of California criminal convictions or incarcerations in recent history. **Even if an individual has no recent California record of conviction or incarceration for certain serious crimes, it does not mean [that the individual has no criminal record elsewhere or] that the individual has not engaged in wrongful behavior.**
4. **Use of Personal Information:** As part of its operations the Registry receives personal information from the Consumer, the County and in some instances third parties about the Consumer's or Provider's participation in the IHSS Program, and about the Consumer's care needs. The Registry will use such information only as for Registry purposes. The Registry

may also use such information to exclude, suspend, or remove a Registry participant for good cause, through confidential procedures. Any disputes concerning exclusions, suspensions and/or removals from the Registry are subject to review and resolution solely by the Registry Review Committee, whose decisions are final and binding upon all concerned, and are not to be the subject of any further proceedings or litigation of any nature.

- 5. **Consumer’s Responsibilities to the Registry:** As an ongoing condition of Registry participation, all Registry participants (Providers and Consumers) must: (a) comply with all Registry policies, procedures and directives, and cooperate fully with Registry personnel; (b) keep the Registry updated as to all decisions regarding referrals; and (c) treat Registry staff and all other Registry participants with civility and respect.

- 6. **Release Agreement:** In consideration for the services to be provided to you by the Registry, you hereby release PASC and Los Angeles County (together with its and their employees, governing board, agents, insurers, contractors, volunteers, and others who have furnished information or services or otherwise cooperated with PASC) from any claims, damages, injuries, liabilities or remedies of any nature relating in any way to the Registry, its services or denial of services, or its actions or failures to act. This Release is also made on behalf of your personal representatives, family, dependents, heirs and assignees. This Release does not affect any rights or claims you may have against a Provider.

- 7. **Signature:** The undersigned has carefully reviewed and considered each and every one of the terms and conditions of this entire Agreement, understands them, and voluntarily decided to agree with them. PASC will rely upon this Agreement when granting Registry services to you.

Personal Assistance Services Council

Signature of IHSS Consumer

Print Name of IHSS Consumer

Date

Home Telephone No.



Simon Golledge,
Interim Chief Executive Officer

Note:

If consumer was assisted in reviewing this agreement, print the name and telephone number of the person who assisted: _____

IHSS Consumers Only

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

(AGENCY OR INDIVIDUAL FROM WHOM INFORMATION IS REQUESTED)

To:

The Department of Public Social Services

1. _____, RESIDING AT _____
Your Name Your Address

_____, HEREBY AUTHORIZE YOU TO RELEASE TO THE

Personal Assistance Services Council (PASC) SPECIFIC
(NAME OF AGENCY, INSTITUTION, INDIVIDUAL PROVIDER)

INFORMATION REQUESTED BY THIS AGENCY WHICH I CANNOT PROVIDE CONCERNING my IHSS case records.

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE Eligibility and participation in services offered by the Personal Assistance Services Council
(PASC), including Registry and other services.

THIS FORM WAS COMPLETED IN ITS ENTIRETY AND WAS READ BY ME (OR READ TO ME) PRIOR TO SIGNING.

SIGNATURE OF APPLICANT		DATE
BIRTHPLACE	BIRTHDATE	MAIDEN NAME OF MOTHER
SIGNATURE OR NAME OF SPOUSE		DATE
BIRTHPLACE OF SPOUSE	BIRTHDATE OF SPOUSE	MAIDEN NAME OF SPOUSE'S MOTHER