Approved:	❒ Yes ❒ No
Approved By:	_____
Approval Date:	_____

IHSS Providers Only

P

PASC Homecare Registry

REGISTRY APPLICATION FORM FOR PROVIDERS

First Name:	**Last Name**:	**Middle Initial**:
IHSS Provider Number:		

Home Phone: (____)___-_____Cell Phone: (___)_____-_____

Message Phone: (____) ____-_____Email Address: _____

Home address:_____Apt. # _____

City:_____State:_____Zip: _____

Gender: ◯ **Male** ◯ **Female** ◯ **Other**_____

Date of Birth:_____

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

Emergency Contact 1:_____Phone_____

Emergency Contact 2:_____Phone _____

What language(s) do you speak? 1:_____ 2:_____

3. Sign Language: _____ Other: _____

Do you plan on moving to another state or county within the next few months?

◯ **Yes, When?**_____ ◯ **No**

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

Please check the tasks you are capable of and willing to perform for the consumer.

- ❒ Domestic Services
- ❒ Preparation of Meals
- ❒ Meal Clean Up
- ❒ Routine Laundry
- ❒ Shopping for Food
- ❒ Other Shopping & Errands
- ❒ Heavy Cleaning
- ❒ Accompany to Dr. App't
- ❒ Accompany to Alternative Resources
- ❒ Remove Grass, Weeds, Rubbish
- ❒ Remove Ice, Snow
- ❒ Shopping for Foods
- ❒ Protective Supervision
- ❒ Teaching & Demonstration
- ❒ Paramedical Services
- ❒ Willing to use your own car
- ❒ Respiration
- ❒ Bowel & Bladder Care
- ❒ Feeding
- ❒ Routine Bed Baths
- ❒ Dressing
- ❒ Menstrual Care
- ❒ Ambulation
- ❒ Moving In/Out of Bed
- ❒ Bathing, Oral Hygiene Grooming
- ❒ Rubbing Skin, Repositioning
- ❒ Care & Assistance With Prosthesis
- ❒ Set Up, Remind Meds
- ❒ Catheter/Colostomy Bag
- ❒ Diapers
- ❒ Exercise
- ❒ Hoyer Lift
- ❒ Lifting/Transfer
- ❒ Memory Problems
- ❒ Toileting
- ❒ Vital Signs
- ❒ Wheelchair Assistance
- ❒ Prosthetic Assistance

Have you had experience and/or training in any of the following? (Check all that apply.)

- ❒ Alzheimer's Disease
- ❒ Arthritis
- ❒ Asthma
- ❒ Bowel Program
- ❒ Cancer
- ❒ Dementia
- ❒ Diabetes
- ❒ Heart Condition
- ❒ HIV/AIDS
- ❒ Hypertension
- ❒ Insulin Care
- ❒ Mental/Emotional Disability
- ❒ Multiple Sclerosis
- ❒ Paralysis
- ❒ Parkinson's Disease
- ❒ Range of Motion
- ❒ Respiration Assistance
- ❒ Seizures
- ❒ Special Diet
- ❒ Spina Bifida
- ❒ Spinal Cord Injury
- ❒ Stroke
- ❒ Traumatic Brain injury
- ❒ Visual Impairment
- ❒ Feeding Tubes
- ❒ Wound Care
- ❒ Lifting Devices/ Hoyer Lift
- ❒ Ventilators

Are you certified in any of the following areas? (Check all that apply) You will be asked to present certification documents.

- ❒ First Aid
- ❒ CPR
- ❒ Certified Nursing Assistant (CNA)
- ❒ Registered Nurse (RN)
- ❒ Home Care Worker Training
- ❒ Vocational Nurse (LVN)
- ❒ Home Health Aide

Years of experience in homecare or similar work: _____

Are you willing to <u>not</u> use perfume or other scented fragrances on the job?
❒ Yes ❒ No

Are you willing to work for a consumer that has a dog? ❒ Yes ❒ No

Are you willing to work for a consumer that has a cat? ❒ Yes ❒ No

Are you willing to work at a home where smoking is practiced?
❒ Yes ❒ No

Are you willing to comply with a no-smoking rule at your consumer's home? ❒ Yes ❒ No

Do you have a driver license? ◯ Yes ◯ No

Do you plan on driving to work? ◯ Yes ◯ No

Are you currently working as an IHSS Provider? ◯ Yes ◯ No

If <u>YES</u>, how many IHSS hours are you currently working per month?_____

How many hours can you work per month?_____

<u>Times of Availability</u>: Flexibility in times you are willing to work gives you an advantage in obtaining referrals. Indicate with a check mark (√) the days and times of day you are willing to work.

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

<u>Areas of Availability</u>: Please list the cities or geographic areas in which you would be willing to work.

_____

_____

Educational Background:

Grade School:
Years completed_____

Middle School:
Years completed_____

High School
Years completed: _____
Did you graduate? ❒ Yes ❒ No

College / University:
Years completed_____
Did you graduate? ❒ Yes ❒ No
Degree / Diploma Earned: _____

Vocational / Trade School:
Years/months completed: _____
Did you graduate? ❒ Yes ❒ No
Degree / Diploma earned:_____

References: (Do not include relatives.) Upon request, the Registry will give these references to any of your prospective employers. Please make sure these numbers are valid and these references have given their consent to be contacted in relation to your job search efforts.

Name	Telephone Number	How long have you known this person?

I certify under penalty of perjury that the information provided above is true and complete to the best of my knowledge. I also understand that any misrepresentation on my part may result in disqualification or removal from the PASC Homecare Registry at any time. I further authorize the Registry and/or the consumer to contact the above references concerning my character and I authorize the Registry to share any such information with others for Registry purposes. I waive any claim(s) I may have regarding any such reference information.

X_____ _____
Signature Date

IMPORTANT -- LEGALLY BINDING AGREEMENT -- REVIEW CAREFULLY

PASC HOMECARE REGISTRY - IHSS PROVIDER'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 the services of the PASC Homecare Registry. The Registry provides referrals of IHSS homecare Providers to participating Consumers. 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 does not perform any background checks of the Consumer participants in Registry programs. Nor does the Registry supervise the Consumer or the employment. You therefore must use your own judgment and assume all risks of accepting or engaging in the employment relationship with any Consumer.**

2. **Consumer is the Employer:** The Consumer has the sole authority to hire, assign duties, supervise, and terminate you, and you have the right to resign from any Consumer's employment. The Registry has no role in such decisions. 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 the Consumer and the Consumer's physician, not the Registry. **PASC has no responsibility for employment matters, for any injuries that may arise out of the referral or the employment, or for investigating or resolving any disputes, losses or injuries that may arise between a Provider and Consumer.**

3. **Availability of Referrals**: The Registry has no control over the nature or volume of Consumer requests for referrals, nor the number of Providers who may be available at any given time, and therefore **the Registry cannot assure the volume of referrals that may be available to Providers at any given time.**

4. **Criminal Background Checks: The statutory authority for determining the standards for disqualification of a prospective or existing IHSS provider is Welfare & Institutions Code (W&IC) Sections 12305.81 and 12305.87**. The Registry abides by prevailing state laws concerning an applicant's eligibility to work as an IHSS Provider. Also, in the event that the Registry learns of a later disqualifying conviction or incarceration, it may report that to the Consumer who is then employing you as a Provider. If any dispute arises concerning the impact of the criminal background check upon a Provider's access to the Registry, it shall be resolved solely under procedures of the Registry Review Committee, and shall not be subject to any further proceedings or litigation of any nature.

5. **<u>Reference Checks – Consent and Release</u>:** You hereby consent to PASC and/or any Consumer contacting your prior employers and personal references, and **you hereby release any prior employers and any references from any claims or liabilities arising out of any statements or information they may provide**.

6. **<u>Use of Personal Information</u>:** 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. 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.

7. **<u>Provider's Responsibilities to the Registry</u>:** 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.

8. **<u>Release Agreement</u>: 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 boards, 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 either under the PASC-SEIU Agreement, or against the State of California under Workers Compensation or Unemployment Insurance laws.

9. **<u>Signature:</u> 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.**

_____
Signature of IHSS Provider/Applicant

_____
Print Name of IHSS Provider/ Applicant

_____
Date

_____
Home Telephone No.

Personal Assistance Services Council

Greg Thompson
Executive Director

Submit