IHSS Consumers Only

PASC Homecare Registry

REGISTRY APPLICATION FORM FOR CONSUMERS

First Name:	Last Name:	Middle Initial:
IHSS Case # : _____ Seven Digits	Social Worker's Name:_____	

Home Phone: (____) _____-_____ **Cell Phone:** (____) _____-_____

☐ By checking this box, you are allowing PASC to send you automated text messages and calls to the phone number you have provided. At any time if you decide you no longer want to receive the information from PASC via text or phone, you can email "Stop" to info@pascla.org. Make sure to include the phone number you are opting out. Standard messaging rates may apply.

Fax: (____)_____-_____ **Email Address:** _____

Home Address:_____ **Apt. #**_____

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

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

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:**_____

3. Sign Language:_____ **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 #**_____

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

◯ Yes ◯ No

If "Yes," please remember that paramedical services are skilled tasks that your doctor or healthcare professional has taught you to do. Therefore it is your responsibility to have your IHSS provider trained on how to provide these services to you.

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

◯ Male ◯ Female ◯ Either

Do you require lifting? ◯ Yes ◯ No

Do you have a Hoyer Lift? ◯ Yes ◯ No

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

Other animals? ◯ Yes ◯ No **Specify:**_____

Do you live near public transportation? ○ **Yes** ○ **No**

Do you maintain a smoke-free environment in your home? ○ **Yes** ○ **No**

Is there anything else you think we should know?

_____

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

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.

Consumer's Signature X_____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
3452 E. Foothill Blvd., Suite 900
Pasadena, CA 91107

Telephone: (818) 206-7000
Toll Free: (877) 565-4477
Fax: (818) 206-8000

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IMPORTANT -- LEGALLY BINDING AGREEMENT -- REVIEW CAREFULLY

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 abides by prevailing state laws concerning an applicant's eligibility to work as an IHSS Provider. **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**.

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.**

_____
Signature of IHSS Consumer

_____
Print Name of IHSS Consumer

_____
Date

_____
Home Telephone No.

Personal Assistance Services Council

Greg Thompson
Executive Director

Note:

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

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

(AGENCY OR INDIVIDUAL FROM WHOM INFORMATION IS REQUESTED)

To:

The Department of Public Social Services

1. _____ (**Your Name**), RESIDING AT _____ (**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 **X**		DATE **X**
BIRTHPLACE	BIRTHDATE	MAIDEN NAME OF MOTHER
SIGNATURE OR NAME OF SPOUSE		DATE
BIRTHPLACE OF SPOUSE	BIRTHDATE OF SPOUSE	MAIDEN NAME OF SPOUSE'S MOTHER

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