



Dear Provider Applicant,

Thank you for your interest in the IHSS Public Authority Provider Registry. Enclosed is an application packet for you to review and complete. Please read and follow the guidelines below so that we may process your application as quickly as possible.

Grass Valley Office
466 Brunswick Road
Grass Valley, CA 95945
Tel: (530) 274-5601
Fax: (530) 274-5602
Toll Free: 866-577-6331

Step #1

Complete the application packet. It includes:

- **Registry Provider Application** – this is the 3 page application form to become an Independent Provider for Recipients who are on the In-Home Supportive Services (IHSS) program. Review, complete and sign.
- **Registry Provider Background form** – this 2 page form gives us permission to contact your references and ask them job-related questions. Review, complete and sign.

Quincy Office
P.O. Box 4323
Quincy, CA 95971
Tel: (530) 283-6052
Fax: (530) 283-6368
Toll Free: 800-242-3338
Ext 6052

Step #2

Mail or deliver the completed application packet to:

Nevada Sierra Regional IHSS Public Authority
466 Brunswick Road
Grass Valley, CA 95945

Website
www.ns-pa.org

Executive Director
Ann Guerra

Step #3

Participate in the Provider Orientation Training. Call Public Authority for appointment.

Bring to your Orientation Appointment:

1. Any forms needed to complete your application packet
2. Current name and telephone numbers for your work and personal references.
3. Your driver's license and social security card or other forms of acceptable ID
4. Proof of current auto insurance (if you would like to drive as part of your provider duties)

The Governing Board
Ana Acton
Mary Tucker
Anita Wald-Tuttle
Nicole Bowden
Jean Newfarmer
Steve Sober
Mark Nagafuchi

Step #4

Be fingerprinted and pass a Live Scan background check. You must pay for your own Live Scan. The Public Authority will provide you with the proper forms, including a list of crimes that would exclude you from working for the IHSS program. The Live Scan cost \$33.00 in exact change.

Please note that applying to the Registry does not guarantee your acceptance. If you have any questions please call us at (530) 274-5601.

We look forward to meeting you soon.

Registry Staff

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)

- African American
- Asian
- Caucasian
- Latino
- Native American
- 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