



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 Consumers 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

Step #3

Participate in the Provider Orientation Training. Once your application has been processed, a Registry Specialist will call you to schedule an orientation.

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)

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.

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
Would you like to be referred to private pay Consumers? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Geographic Preference

Nevada County
<input type="checkbox"/> Cedar Ridge
<input type="checkbox"/> Chicago Park
<input type="checkbox"/> Floriston
<input type="checkbox"/> Grass Valley
<input type="checkbox"/> Nevada City
<input type="checkbox"/> North San Juan
<input type="checkbox"/> Penn Valley
<input type="checkbox"/> Rough & Ready
<input type="checkbox"/> Lake of the Pines
<input type="checkbox"/> Smartsville
<input type="checkbox"/> Truckee
<input type="checkbox"/> Washington

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

Registry Provider Background & References Release

Name: _____
(Please Print) *Last, First, Middle Initial*

Other names you have used or been known by (maiden name): _____

Mailing Address: _____

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

Contact Information: *Please list phone numbers where you can be reached. Identify the type of number such as home, cell, message. (One phone number is required)*

Phone number _____ **Type:** _____ **Phone number** _____ **Type:** _____

Best times to reach me: _____

Male **Female** **Date of Birth:** _____ **Social Security Number:** _____

References: *Please list two work references and one personal reference. DO NOT USE FAMILY MEMBERS.*

Two Work References: List name of reference, Company Name, Telephone Number, position held and number of years worked.

1. **Name:** _____ **Company** _____ **Phone:** _____

Relationship to Reference _____ **Dates of Employment** _____

2. **Name:** _____ **Company** _____ **Phone:** _____

Relationship to Reference _____ **Dates of Employment** _____

3. **Name:** _____ **Company** _____ **Phone:** _____

Relationship to Reference _____ **How Long Known:** _____

Background:

List the dates of residence and counties you have lived within the last ten (10) years:

List all Counties in which you have lived within the last 10 years:			
County	Start Date	End Date	Name Used

Have you been convicted of a **felony or misdemeanor** charge, or been on parole or probation?
 Failure to disclose this information will automatically disqualify you from acceptance to the Registry
 Yes **No**

If “Yes,” list all convictions in the last 10 years below. A “Yes” answer to this question does not automatically disqualify you for the Registry. Each case is considered individually.

List the offense, date and place of conviction, sentence and date of release from custody and/or from probation/parole, and any other facts you want considered.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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, to contact any and all references, and to obtain any criminal background check information. 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