

CONTRA COSTA COUNTY IHSS PUBLIC AUTHORITY

500 Ellinwood Way Suite 110 Pleasant Hill, CA 94523 1-800-333-1081

Registry Provider Application

All applicants to the Public Authority Provider Registry will be required to undergo a Department of Justice Criminal Background Investigation to determine if the applicant has ever been convicted of certain violations of the Penal Code. Applicants who do not "clear" the DOJ check will not be listed on the Registry. The cost for fingerprinting is the applicant's responsibility (the cost is approximately \$70).

Note: An incomplete application will delay processing

Name: _____ Male
Last First Middle Female
Mailing Address: _____
Number Street Apt# City Zip
Phone: (____) _____ (____) _____ Social Security # ____ - ____ - ____
Birth Date: ____ - ____ - ____ Email: _____

Days and Hours Desired:

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Mornings:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoons:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evenings:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overnight:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Can you work?
 Holidays
 1-2 Hour Shifts
 On-Call

Hours desired per week: _____

Geographic Please check the cities where you are able to work:

- Central County**
- Alamo
 - Clayton
 - Concord
 - Danville
 - Lafayette
 - Martinez
 - Moraga
 - Orinda
 - Pacheco
 - Pleasant Hill
 - San Ramon
 - Walnut Creek

- East County**
- Antioch
 - Bay Point
 - Bethel Island
 - Brentwood
 - Byron
 - Knightsen
 - Oakley
 - Pittsburg

- West County**
- Crockett
 - El Cerrito
 - El Sobrante
 - Hercules
 - Kensington
 - Pinole
 - Port Costa
 - Richmond
 - Rodeo
 - San Pablo

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
Form of transportation	<input type="checkbox"/> Car <input type="checkbox"/> Bus	Live In Position?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Read/Write English?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Client Preference?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Either
Will you use your car?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drive Client Car?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will you work with pets?	<input type="checkbox"/> Yes <input type="checkbox"/> No	On-Call / Temporary Work?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Type of Work Desired

<input type="checkbox"/> Domestic Services	<input type="checkbox"/> Ambulation
<input type="checkbox"/> Preparation of Meals	<input type="checkbox"/> Moving In/Out of Bed
<input type="checkbox"/> Meal Clean up	<input type="checkbox"/> Bathing – Oral Hygiene - Grooming
<input type="checkbox"/> Routine Laundry	<input type="checkbox"/> Rubbing Skin - Repositioning
<input type="checkbox"/> Shopping for food	<input type="checkbox"/> Care and assistance with prosthesis
<input type="checkbox"/> Other Shopping and Errands	<input type="checkbox"/> Accompaniment to Medical Appointments
<input type="checkbox"/> Heavy cleaning	<input type="checkbox"/> Accompaniment to Alternative Resources
<input type="checkbox"/> Respiration	<input type="checkbox"/> Protective Supervision
<input type="checkbox"/> Bowel & Bladder Care	<input type="checkbox"/> Teaching and Demonstration
<input type="checkbox"/> Feeding	<input type="checkbox"/> Paramedical Services
<input type="checkbox"/> Routine Bed Baths	
<input type="checkbox"/> Dressing	
<input type="checkbox"/> Menstrual Care	

Willing to Work With

<input type="checkbox"/> Women	<input type="checkbox"/> Dementia
<input type="checkbox"/> Men	<input type="checkbox"/> Memory Problems
<input type="checkbox"/> Elderly	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Children	<input type="checkbox"/> Terminal Illness
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Developmental Disabilities
<input type="checkbox"/> Blind or Visually Impaired	

Languages Spoken

- | | | | | |
|--|----------------------------------|-------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> American Sign | <input type="checkbox"/> Farsi | <input type="checkbox"/> Japanese | <input type="checkbox"/> Russian | <input type="checkbox"/> Gujarati |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> French | <input type="checkbox"/> Korean | <input type="checkbox"/> Spanish | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> German | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Punjabi |
| <input type="checkbox"/> English | <input type="checkbox"/> Italian | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Vietnamese | |
| <input type="checkbox"/> Other _____ | | | | |

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Are you willing to submit to random drug testing? Yes No

Please list any certificates, licenses or Home Care related training you have:

First Aid Expires _____ CNA Expires _____

CPR Expires _____ CNHA Expires _____

Other(s) _____

Home Care related training: _____

How many years have you worked as a Home Care provider? _____

Have you ever worked as an (IHSS) In-Home Supportive Services Provider? Yes No

How many years have you worked as an IHSS Provider? _____

How did you hear about us? _____

Personal References

Please list two names of people who know you personally whom we can contact as character references. Personal References must be different from Work References.

Please DO NOT list family members as references.

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1. Name: _____ Hm Phone:() _____ Wk Phone: () _____

How do you know? _____ How long known: _____

2. Name: _____ Hm Phone:() _____ Wk Phone: () _____

How do you know? _____ How long known: _____

This section is Optional (not required). This information will be kept confidential and used only by staff for statistical purposes and to improve opportunities for care providers.

Birth Date: _____ Do you have health insurance? Medi-Cal Yes Other None

Ethnicity: African American Asian-Pacific Islands Caucasian
 Native American Latino Other _____

Application Certification

I certify that the information on this application is true. I understand that any false information may eliminate me from consideration. I understand that being accepted to the Public Authority Provider Registry means my name may be included on lists given to persons who are seeking assistance in their homes.

I understand that the information on this application may be shared with prospective employers. I understand that my employer is not Contra Costa In-Home Supportive Services (IHSS). The IHSS client is my employer. I understand that I am responsible for paying the fees associated with the Criminal Background Investigation (CBI).

I understand that passing CBI does not guarantee employment. **I understand that the Public Authority does NOT guarantee employment.** The Public Authority Provider Registry is a referral service for consumers and providers; it is not an employment agency.

Signature

Date

Public Authority Use Only

Interviewer: _____

Interview Date: _____