INDEPENDENT PROVIDER APPLICATION

**To Join the Tehama County Public Authority Registry**

| COUNTY USE ONLY | |
|---|---|
| Active Provider | |
| Entered in Nexus | |
| DOJ Check | |
| Approved/Denied | |

**All information on this form is required, including verifiable references**

**First Name:** ____________________ **M:** ______ **Last Name:** ________________________

**Social Security Number:** __________________________ **DOB:** ______________________

**Gender: M___ F___ Email Address:** ____________________________________________

**Required for monthly updates and electronic monthly check-in

**Address:** ___________________________________________________________________

Street City Zip Code

**Mailing Address (if different):** _________________________________________________

**Home Phone:** _____________________ **Mobile Phone:** ___________________________

**Driver's License No. or CA ID:** _____________________ **Expiration Date:** ______________

**U.S. CITIZEN? Yes___ No___ GREEN CARD:** ____________________________________

Card No. Expiration Date

**NUMBER OF HOURS PER WEEK YOU WOULD LIKE TO WORK (Max. 66 hours):** _________

**Please tell us a little more about your preferences:**

**1. What is your client preference?** Male ___ Female ___ Either___

**4. Will you work around pets?** Yes___ No___

**If yes, select all that apply:** Cats____ Dogs____ Birds (Caged)____ Reptiles(Caged)____

**5. Primary Language:** ___________________________________________________

**Other languages spoken fluently (If applicable):** ___________________________

**6. Do you sign/know American Sign Language (ASL)?** Yes ___ No ____

**7. I have been providing care since:** _____________

**8. How did you hear about us?** ________________________

Monthly check-in is required to remain on the registry. Providers who do not check in for longer than 60 days will be removed from the registry until we are notified otherwise. Providers can check in via email check-in reminders, or by contacting the Public Authority at (530) 527-2466 or tehamapa@tcdss.org

**I am willing to work in the following environments (check all that apply):**

- ☐ Adult with developmental disabilities: Autism, Brain Injury, Cerebral Palsy, Epilepsy, etc.
- ☐ Adult with physical disabilities
- ☐ Clients with Alzheimer's or Dementia
- ☐ Clients who are blind or vision impaired
- ☐ Child/minor with developmental disabilities: Autism, Brain Injury, Cerebral Palsy, Epilepsy, etc.
- ☐ Child/minor with physical disabilities
- ☐ Contagious Disease (Infectious disease or Transmitted disease)
- ☐ COVID-19
- ☐ Clients who are deaf or hearing impaired
- ☐ Clients who are elderly
- ☐ Clients who need Hospice care
- ☐ Clients that have memory problems
- ☐ Clients with mental health issues: Bi-Polar, hoarding, depression Schizophrenia, etc.
- ☐ Clients who are quadriplegic
- ☐ Clients with allergies, must be scent-free (no perfume, scent-free soaps and lotions)
- ☐ Clients who have a speech impairment or unable to speak

**Smoking preference (check one):**

- ☐ No preference if there is smoking or not
- ☐ Clients who do NOT smoke at all
- ☐ Clients who smoke inside and outside their home
- ☐ Clients who smoke outside only

**Tell us more about yourself (check all that apply)**

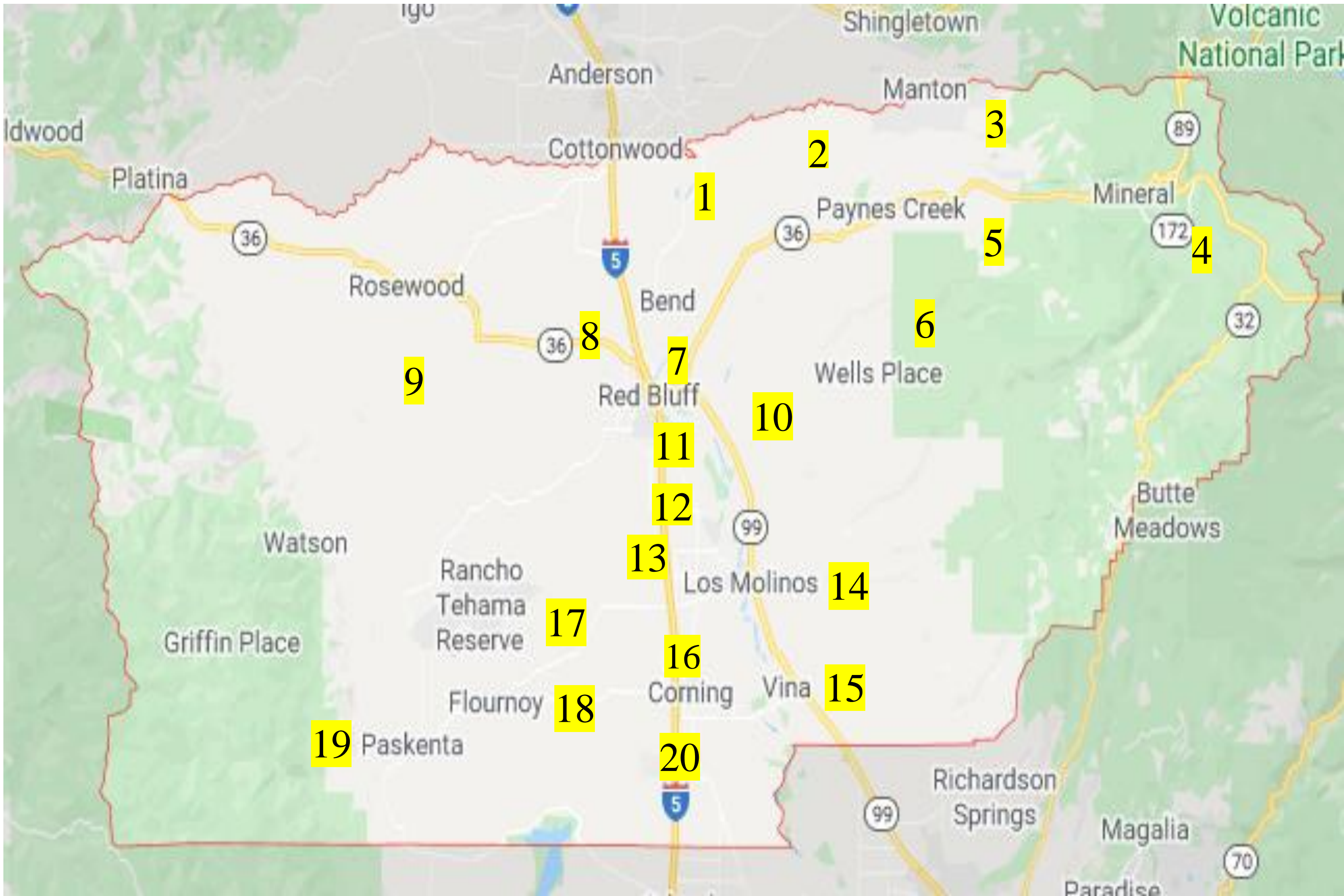
- ☐ I have a car/vehicle equipped with a ramp/lift
- ☐ I am willing to transport clients to medical appointments or other locations, using my own vehicle
- ☐ I can read and write in English
- ☐ I can be an emergency/back-up provider (Temporary care until recipient finds permanent provider)
- ☐ I can work on Holidays
- ☐ I can become a live in provider
- ☐ I can be available for short term relief
- ☐ I can be available for urgent care
- ☐ I can transfer obese consumers
- ☐ I can do transfers with a Gait Belt (Assistance using belt to move recipient/help walk around)
- ☐ I can do transfers with a Hoyer Lift (Machine with sling to help move client)
- ☐ I can do a Pivot Transfer (Moving client from one surface to another)
- ☐ I can do transfers using a Sliding Board (Moving client with the help of a sliding board)
- ☐ I will work with Diabetics

**Smoking (check one):**

☐ I do not smoke
☐ I smoke while working
☐ I smoke only outside while on breaks or lunch
☐ I smoke, but not at all while I am at work

**I am willing to do the following services (check all that apply):**

☐ Domestic services (cleaning, sweeping vacuuming, etc.)
☐ Preparation of meals
☐ Cleaning-up after meals
☐ Laundry
☐ Shopping for food
☐ Other shopping/errands (medication pick-up, food pick-up, etc.)
☐ Respiration
☐ Bowel & bladder care
☐ Feeding
☐ Routing bed baths
☐ Dressing
☐ Menstrual care
☐ Ambulation (walking assistance with cane, walker and/or wheelchair)
☐ Transfer (transferring the client from bed to wheelchair, or wheelchair to toilet, etc.)
☐ Bathing, oral hygiene, and grooming (shaving, brushing teeth, etc.)
☐ Rubbing skin, repositioning
☐ Care & assistance with prostheses (medication reminders)
☐ Accompaniment to medical appointments
☐ Accompaniment to alternative resources
☐ Protective supervision
☐ Paramedical services
☐ Heavy cleaning
☐ Yard hazard abatement
☐ Removal of Snow, Ice
☐ Teaching and demonstration




**I am willing to work in the following areas of Tehama County (check all that apply):**

| | Corning | Area 16 |
|---|---|---|
| | Corning – Kirkwood (Capay) | Area 20 |
| | Cottonwood | Area 1 |
| | Dairyville | Area 10 |
| | Flournoy | Area 18 |
| | Gerber | Area 12 |
| | Lake California | Area 2 |
| | Los Molinos | Area 14 |
| | Manton Area | Area 3 |
| | Mineral | Area 4 |

| | Paskenta | Area 19 |
|---|---|---|
| | Paynes Creek | Area 5 |
| | Proberta | Area 11 |
| | Rancho Tehama | Area 17 |
| | Red Bluff – Central East | Area 7 |
| | Red Bluff – Central West | Area 8 |
| | Red Bluff – Rural East | Area 6 |
| | Red Bluff Rural West | Area 9 |
| | Tehama | Area 13 |
| | Vina | Area 15 |

**List any training (and date of training) you have had related to in-home care.**
**Please include any training you attended through Public Authority Services:**

______________________________________________________________________________

______________________________________________________________________________

**LIST ANY CERTIFICATES OR LICENSES YOU POSSESS:** (Please use extra sheet if necessary)

______________________________________________________________________________
Certificate/license Institution Expiration Date

______________________________________________________________________________
Certificate/license Institution Expiration Date

**LIST YOUR WORK REFERENCES BELOW. YOU MUST PROVIDE 2 POSTIVE WORK REFERENCES FROM WITHIN THE LAST 3 YEARS. MAKE ENSURE YOU PROVIDE VALID PHONE NUMBERS (if you have not worked in the last 3 years, you please provide personal references):**
(Please use extra sheet if necessary)

**WORK REFERENCE #1:**

EMPLOYED FROM: ________________ TO: _________________ HOURS WORKED PER WEEK ______
Month/Year Month/Year

CLIENT OR COMPANY NAME: ___________________________________________________________

NAME OF SUPERVISOR: ____________________________________ PHONE: ____________________

JOB TITLE AND DUTIES: _________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**WORK REFERENCE #2:**

EMPLOYED FROM: ________________ TO: _________________ HOURS WORKED PER WEEK ______
Month/Year Month/Year

CLIENT OR COMPANY NAME: ___________________________________________________________

NAME OF SUPERVISOR: ____________________________________ PHONE: ____________________

JOB TITLE AND DUTIES: _________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**HAVE YOU EVER BEEN CONVICTED BY ANY COURT OF A CRIME? Yes___ No___**

**If yes, please explain:** __________________________________________________________________

______________________________________________________________________________

**I declare that all information provided is correct and true. I understand that misrepresentation or omission of facts called for is cause for removal from the Public Authority Registry. As a referral service, the Public Authority Registry retains the exclusive right to exercise discernment in its selection of providers. The process is selective: receiving an invitation to a Provider Orientation and/or interview session is not a guarantee of acceptance onto the Registry. The Registry operates as an optional and non-compulsory service to refer IHSS providers to consumers, and all providers may work for any consenting IHSS consumer without being a part of the Registry. Removal or rejection from the Registry does not preclude an individual from working as an IHSS provider. PLEASE NOTE: If you are receiving any form of public assistance, be aware that as per the Welfare and Institutions Code 10850, this application may be shared with other government agencies as applicable.**

| ______________________________________ | ______________________ |
|---|---|
| **Signature of Applicant** | **Date** |