SFIHSS PUBLIC AUTHORITY

# PROVIDER APPLICATION

832 Folsom Street, 9th Floor ▪ San Francisco, CA 94107
(415) 243-4477 ▪ info@sfihsspa.org ▪ www.sfihsspa.org

| | |
|---|---|
| Date Received: | |
| Date Accepted: | |
| Interviewer: | |
| Reviewer: | |
| Referred by: | |

| | | | | |
|---|---|---|---|---|
| Name: | LAST | FIRST | M.I. | PREFERRED NAME |
| Mailing Address: | STREET | CITY | STATE | ZIP CODE |
| Residence Address: | STREET | CITY | STATE | ZIP CODE |
| Mobile Phone: | | Home Phone: | | Other Phone: |
| Permission to Text: | ☐ Yes ☐ No | Email: | | |
| IHSS Provider #: *(If Available)* | | | | |

*This section is OPTIONAL, but may provide useful information to the Registry.*
*Gender will be used only when a consumer requests a worker of the same gender to provide personal care.*

| | | | |
|---|---|---|---|
| Gender: | ☐ Male | ☐ Transgender Male to Female | ☐ Another Gender Identity ☐ Non-Binary |
| | ☐ Female | ☐ Transgender Female to Male | ☐ Declined to State Identity |
| Pronouns: | ☐ He/Him | ☐ They/Them | ☐ Other: |
| | ☐ She/Her | ☐ Ze/Hir | |
| Race/Ethnicity: | ☐ White | ☐ Latinx | ☐ Other: |
| | ☐ Black | ☐ Asian or Pacific Islander | |

## LANGUAGES

| | |
|---|---|
| English Fluency Level: | ☐ Fluent ☐ Limited ☐ No English |
| Preferred Spoken Language: *(including English)* | |
| Preferred Written Language: *(including English)* | |
| Other Language: | |

## ACCESSIBILITY

| | | |
|---|---|---|
| **Do you rely on public transportation to get to jobs?** | ☐ Yes | ☐ No |
| **Are you willing to use your own car to transport your Consumer(s)?** | ☐ Yes* | ☐ No |
| **Are you willing to drive a consumer's car?** | ☐ Yes* | ☐ No |

** If yes, you must have a current driver's license and auto insurance.*
*IHSS does not pay for transportation services; gas, mileage, maintenance, etc.*

## TRAINING & CERTIFICATION

| CERTIFIED TRAINING | COMPLETED TRAINING | COMPLETION DATE |
|---|---|---|
| **Homebridge Basic 48-hour Training:** | ☐ Yes ☐ No | |
| **Homebridge Basic 48-hour Training Online:** | ☐ Yes ☐ No | |
| **Homebridge Workshops or Specialized Trainings:** | ☐ Yes ☐ No | |
| **CPR / First Aid** (Cardio-Pulmonary Resuscitation): | ☐ Yes ☐ No | |
| **Do you have a Tuberculosis Test Clearance?** | ☐ Yes** ☐ No | *** IF YES, RESULT DATE:* |
| **Do you have proof of COVID-19 vaccination?** | ☐ Yes ☐ No | |
| **Number of Years of Caregiving Experience :** | | |

## OTHER RELEVANT INFORMATION

| | | | |
|---|---|---|---|
| **Do you smoke?** | ☐ Yes ☐ No | **Will you work for consumers who smoke?** | ☐ Yes ☐ No |

**Do you have an allergy that would affect your ability to work in a home with?**

| | | | | | |
|---|---|---|---|---|---|
| **Cats:** | ☐ Yes ☐ No | **Dogs:** | ☐ Yes ☐ No | **Other:** | |

| | |
|---|---|
| **Are you willing to provide IP services in the event of a disaster?** | ☐ Yes*** ☐ No |
| ******* If yes, please check all that apply:*** | ☐ Consumer's Home<br>☐ Emergency Shelter |

| | | | |
|---|---|---|---|
| **Scent Usage:** | ☐ Uses scents<br>☐ Does not use scents | **Scent Sensitivity:** | ☐ Must work in scent-free home<br>☐ Willing to work with people who use scents |

# WORK PREFERENCES

**Please check boxes indicating all your preferences / that which you are willing to work with:**

*We cannot guarantee that consumers service needs will match all your preferences.*
*We encourage you to consider performing all tasks and serving all consumers.*

## CLIENT GENDER

- ☐ Males
- ☐ Females
- ☐ Other / Non-binary

## CLIENT TYPES

- ☐ Child / Minor
- ☐ Cognitive / Psych Disability *(dementia, bipolar, etc.)*
- ☐ Palliative Care *(hospice / end of life)*

## DOMESTIC TASKS

- ☐ Accompaniment to Alternate Resources
- ☐ Accompaniment to Medical Appointments
- ☐ Domestic Services
- ☐ Heavy Cleaning
- ☐ Meals Clean Up
- ☐ Other Shopping & Errands
- ☐ Paramedical Services
- ☐ Preparation of Meals
- ☐ Protective Supervision
- ☐ Yard Hazard Abatement
- ☐ Remove Ice / Snow
- ☐ Routine Laundry
- ☐ Shopping for Food
- ☐ Teaching & Demonstration

## PERSONAL TASKS

- ☐ Respiration
- ☐ Bowel & Bladder Care
- ☐ Feeding
- ☐ Routine Bed Baths
- ☐ Dressing
- ☐ Menstrual Care
- ☐ Ambulation
- ☐ Moving In / Out of Bed
- ☐ Bathing / Oral Hygiene / Grooming
- ☐ Rubbing Skin / Repositioning
- ☐ Care & Assistance with Prosthesis
- ☐ Set Up / Remind Meds
- ☐ Catheter / Colostomy Bag
- ☐ Diapers
- ☐ Exercise
- ☐ Hoyer Lift
- ☐ Lifting / Transferring
- ☐ Memory Problems
- ☐ Toileting
- ☐ Vital Signs

## SCHEDULE & GEOGRAPHIC PREFERENCES

**Number of hours per week you are willing to work** *(check all that apply)*:

*Most consumers need part-time workers. You can accept more than one part-time job if you prefer a full-time schedule.*

- ☐ **10 hours or less/week** *(part time)*
- ☐ **10 – 25 hours/week** *(part time)*
- ☐ **25 hours or more/week** *(full time)*
- ☐ **Long-term**
- ☐ **'Temporary Assignment'** *(work from a couple of days to a couple of months)*

**Check all the days and times you are available to work weekly:**

| | | MON | TUES | WED | THUR | FRI | SAT | SUN |
|---|---|---|---|---|---|---|---|---|
| **MORNINGS** | *Anytime between* ***6 am – 12 pm*** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **AFTERNOONS** | *Anytime between* ***12 pm – 5 pm*** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **EVENINGS** | *Anytime between* ***5 pm – 10 pm*** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **OVERNIGHT** | *Anytime between* ***10 pm – 6 am*** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Please check off all the locations you would be willing to work:**

*The more areas you are willing to work in, the more jobs you may be referred to.*

- ☐ Bayview
- ☐ Bernal Heights
- ☐ Castro
- ☐ Chinatown
- ☐ Civic Center
- ☐ Cole Valley
- ☐ Downtown / Financial District
- ☐ Duboce Triangle
- ☐ Embarcadero / Northern Waterfront
- ☐ Excelsior
- ☐ Fisherman's Wharf
- ☐ Glen Park
- ☐ Haight Ashbury
- ☐ Hayes Valley
- ☐ Ingleside
- ☐ Inner Sunset
- ☐ Japantown
- ☐ Lower Haight
- ☐ Marina
- ☐ Mission Bay
- ☐ Mission District
- ☐ Nob Hill
- ☐ Noe Valley
- ☐ North Beach
- ☐ Outer Sunset
- ☐ Pacific Heights
- ☐ Pacific Heights / Lower Pacific Heights
- ☐ Parkside / Lake Merced
- ☐ Portola
- ☐ Potrero Hill
- ☐ Presidio
- ☐ Richmond
- ☐ Russian Hill
- ☐ SoMa
- ☐ South Beach
- ☐ Tenderloin
- ☐ Treasure Island
- ☐ Twin Peaks
- ☐ Visitacion Valley
- ☐ Western Addition
- ☐ West Portal

| SF Neighborhood you live in: | | … or other county: | |
|---|---|---|---|

## WORK HISTORY

List one verifiable work reference *(home care experience preferred)*, or volunteer work experience *within the past five years*...

| | | | |
|---|---|---|---|
| **Employer:** | | **Phone #:** | |
| **Job Title and Responsibilities:** | | **Permission to Call:** | ☐ Yes ☐ No |
| **Job Supervisor's or Consumer's Name:** | **Period of Employment:** | *FROM (MONTH/YEAR)* | *TO (MONTH/YEAR)* |
| **Reason for Leaving:** | | | |

## PERSONAL REFERENCES

*... plus* two personal references who *are not relatives*.
*Please do not list family members (sisters, nieces, grandparents, etc.)*

| | | | | | |
|---|---|---|---|---|---|
| **Name:** | | **Relationship:** | | **Phone #:** | |
| **Name:** | | **Relationship:** | | **Phone #:** | |

I certify that all information on this form is true to the best of my knowledge and that any omission or misrepresentation of information may disqualify me from being listed in the registry. I also understand that submitting an incomplete application will disqualify me from being considered for the Registry.

I understand the Public Authority is a referral agency, and job placement is not guaranteed. I give the Public Authority permission to share relevant information in my file with individual Consumers who are looking for Independent Home Care Providers.

I agree to keep confidential all information regarding Consumers and services I provide. I understand that per state law if I knowingly and intentionally violate this confidentiality agreement, I would be guilty of a misdemeanor.

I authorize the SF IHSS Public Authority (SFIHSSPA) and its consumers to contact me via text messages to my cell phone and telephone calls as well. I understand that text messaging rates will apply to any messages received from the SFIHSSPA. I also understand that I can opt-out at any time. I agree not to hold SFIHSSPA liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my contact/cell phone number changes that I will inform SFIHSSPA or be liable for any fees or charges incurred. Additionally, SF IHSS Public Authority staff can also contact me through my e-mail address (If provided) and by mail as well.

| | | | |
|---|---|---|---|
| **Signature:** | | **Date:** | |