



SFIHSS PUBLIC
AUTHORITY

PROVIDER APPLICATION

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

Date Received:

Date Accepted:

Interviewer:

Reviewer:

Referred by:

Name:	<small>LAST</small>		<small>FIRST</small>	<small>M.I.</small>	<small>PREFERRED NAME</small>
Mailing Address:	<small>STREET</small>		<small>CITY</small>	<small>STATE</small>	<small>ZIP CODE</small>
Residence Address:	<small>STREET</small>		<small>CITY</small>	<small>STATE</small>	<small>ZIP CODE</small>
Mobile Phone:		Home Phone:		Other Phone:	
Permission to Text:	<input type="checkbox"/> Yes <input type="checkbox"/> No		Email:		
IHSS Provider #: <small>(If Available)</small>					
<i>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.</i>					
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Another Gender Identity <input type="checkbox"/> Non-Binary <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Declined to State Identity				
Pronouns:	<input type="checkbox"/> He/Him <input type="checkbox"/> They/Them <input type="checkbox"/> Other: <input type="checkbox"/> She/Her <input type="checkbox"/> Ze/Hir				
Race/Ethnicity:	<input type="checkbox"/> White <input type="checkbox"/> Latinx <input type="checkbox"/> Other: <input type="checkbox"/> Black <input type="checkbox"/> Asian or Pacific Islander				

LANGUAGES

English Fluency Level:	<input type="checkbox"/> Fluent <input type="checkbox"/> Limited <input type="checkbox"/> No English		
Preferred Spoken Language: <small>(including English)</small>			
Preferred Written Language: <small>(including English)</small>			
Other Language:			

ACCESSIBILITY

Do you rely on public transportation to get to jobs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you willing to use your own car to transport your Consumer(s)?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
Are you willing to drive a consumer's car?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
<p><i>* If yes, you must have a current driver's license and auto insurance. IHSS does not pay for transportation services; gas, mileage, maintenance, etc.</i></p>		

TRAINING & CERTIFICATION

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

OTHER RELEVANT INFORMATION

Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Will you work for consumers who smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an allergy that would affect your ability to work in a home with?			
Cats:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dogs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Other:	
Are you willing to provide IP services in the event of a disaster?		<input type="checkbox"/> Yes*** <input type="checkbox"/> No	
<i>*** If yes, please check all that apply:</i>		<input type="checkbox"/> Consumer's Home <input type="checkbox"/> Emergency Shelter	
Scent Usage:	<input type="checkbox"/> Uses scents <input type="checkbox"/> Does not use scents	Scent Sensitivity:	<input type="checkbox"/> Must work in scent-free home <input type="checkbox"/> 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	DOMESTIC TASKS	PERSONAL TASKS
<input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Other / Non-binary	<input type="checkbox"/> Accompaniment to Alternate Resources <input type="checkbox"/> Accompaniment to Medical Appointments <input type="checkbox"/> Domestic Services <input type="checkbox"/> Heavy Cleaning <input type="checkbox"/> Meals Clean Up <input type="checkbox"/> Other Shopping & Errands <input type="checkbox"/> Paramedical Services <input type="checkbox"/> Preparation of Meals <input type="checkbox"/> Protective Supervision <input type="checkbox"/> Yard Hazard Abatement <input type="checkbox"/> Remove Ice / Snow <input type="checkbox"/> Routine Laundry <input type="checkbox"/> Shopping for Food <input type="checkbox"/> Teaching & Demonstration	<input type="checkbox"/> Respiration <input type="checkbox"/> Bowel & Bladder Care <input type="checkbox"/> Feeding <input type="checkbox"/> Routine Bed Baths <input type="checkbox"/> Dressing <input type="checkbox"/> Menstrual Care <input type="checkbox"/> Ambulation <input type="checkbox"/> Moving In / Out of Bed <input type="checkbox"/> Bathing / Oral Hygiene / Grooming <input type="checkbox"/> Rubbing Skin / Repositioning <input type="checkbox"/> Care & Assistance with Prosthesis <input type="checkbox"/> Set Up / Remind Meds <input type="checkbox"/> Catheter / Colostomy Bag <input type="checkbox"/> Diapers <input type="checkbox"/> Exercise <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> Lifting / Transferring <input type="checkbox"/> Memory Problems <input type="checkbox"/> Toileting <input type="checkbox"/> Vital Signs
CLIENT TYPES		
<input type="checkbox"/> Child / Minor <input type="checkbox"/> Cognitive / Psych Disability <i>(dementia, bipolar, etc.)</i> <input type="checkbox"/> Palliative Care <i>(hospice / end of life)</i>		

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.

- | | | |
|---|---|---|
| <input type="checkbox"/> 10 hours or less/week
<i>(part time)</i> | <input type="checkbox"/> 10 - 25 hours/week
<i>(part time)</i> | <input type="checkbox"/> 25 hours or more/week
<i>(full time)</i> |
| <input type="checkbox"/> Long-term | <input type="checkbox"/> 'Temporary Assignment'
<i>(work from a couple of days to a couple of months)</i> | |

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

		MON	TUES	WED	THUR	FRI	SAT	SUN
MORNINGS	<i>Anytime between 6 am - 12 pm</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AFTERNOONS	<i>Anytime between 12 pm - 5 pm</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EVENINGS	<i>Anytime between 5 pm - 10 pm</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OVERNIGHT	<i>Anytime between 10 pm - 6 am</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

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

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:	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	
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