San Joaquin Cares...

IHSS Public Authority

Dear Applicant,

Thank you for your interest in applying for the In-Home Supportive Services Public Authority Provider Registry. This is not a job application. If you are accepted to the Registry, we will refer you to IHSS Recipients based on your availability and how your application matches the clients' needs. The clients will make all interviewing and hiring decisions. There is no guarantee of referrals to IHSS Recipients, to interviews, or to hiring.

Included in this application packet are:

1. The application.

The three reference questionnaires to be completed by your references (2 personals and 1 employment). You must have your references complete their questionnaire. **Do not use relatives as your references. Employment reference needs to be completed by either HR, Manager or Supervisor of where you work/worked.** **References may phone in their responses if needed to Nicole @** 209-**468-1747.**

2. Applications must be complete and include 3 completed reference questionnaires.
   Please submit your completed application packet by email or fax:

Email: nlinsenbigler@sjgov.org
Fax: 209-944-8913

Applicants accepted for the Registry are required to pass a background check to meet the requirements set in Federal, State, and local laws to become an in-home care provider for IHSS.

You will be notified of your application status by mail within approximately 10 business days after the Public Authority receives your application.

***If you already have an IHSS Recipient who would like to hire you as their provider you do not need to fill out this application.*

Please return this application by fax (209-944-8913) or email (nlinsenbigler@sjgov.org)

IHSS Public Authority 1-800-491-1996

In-Home Supportive Services
IHSS Public Authority
San Joaquin County

Mission Statement

To enhance availability of resources, ensure safety, and promote quality service for In-Home Supportive Services consumers.

Values Statement

The recipient should be able, to the greatest extent possible:

- Make decisions concerning the services they receive
- Have assistance in locating IHSS providers
- Have access to emergency resources
- Have access to training and learning tools to improve interpersonal skills with IHSS providers
- Have providers who are available, trustworthy, and reliable to meet the service needs of the recipient.

Important Phone Numbers:

Public Authority Registry

1 (800) 491-1996

Adult Protective Services

1 (888) 800-4800

IHSS General Information

(209) 468-2202

IHSS Payroll

(209) 468-1706

SEIU-2015

(855) 810-2015

San Joaquin County

IHSS Public Authority

24 S. Hunter St. Room 5

Stockton, CA 95202

1 (800) 491-1996

Fax (209) 944-8913

Registry Services

IHSS Public Authority

San Joaquin Cares...

IHSS Public Authority

In-Home Supportive Services Public Authority

The IHSS Public Authority was established by local ordinance 4147 in 2002 by the San Joaquin County Board of Supervisors.

The IHSS Public Authority is a local government agency created to improve the delivery of services to IHSS recipients and Homecare providers.

In January 2003, the Public Authority officially opened for business and in May 2003, the Public Authority Registry was created. The Registry's main goal is to assist recipients in finding homecare providers so that they may live safely at home. All Registry services are provided in accordance with the Individual Provider (IP) mode, which guarantees the IHSS recipient's right to hire, supervise, train, and when necessary, fire the homecare provider.

The IHSS Public Authority is responsible for specific tasks to enhance services to providers and recipients of In-Home Supportive Services in San Joaquin County.

What Does the IHSS Public Authority Do?

- Operates a registry of available IHSS independent homecare providers
- Performs reference and background checks
- Provides lists of screened providers to recipients to interview
- Helps IHSS recipients conduct interviews to choose a provider
- Provides a training orientation for new IHSS registry providers
- Offers information and training for IHSS recipients on how to hire and supervise providers
- Provides information to IHSS providers on local training programs in health care professions
- Assists both recipients and providers in resolving conflicts
- Serves as employer of record for all independent IHSS providers for collective bargaining purposes

What is IHSS?

The IHSS Program helps low income elderly, blind and disabled individuals remain in their own homes when they are not able to fully care for themselves.

The program pays for a wide variety of services: household chores and personal care—enabling the recipient to live safely in their own home while encouraging self-reliance and independence. IHSS assists in helping recipients remain at home to prevent or delay using out of home care facilities.

Who is a Recipient?

An IHSS recipient is a qualified eligible aged, blind, or disabled person who is unable to live safely at home without assistance. A recipient is also referred to as a consumer or client.

Who is a Provider?

A care provider is a person who provides personal and domestic services to IHSS eligible recipients. A provider is also referred to as a Caregiver.

For more information on eligibility call the San Joaquin County Human Services Agency at (209) 468-2202 to speak with an IHSS Cover Worker.

San Joaquin Cares...
IHSS Public Authority

IHSS Public Authority
Registry Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Social Security No.: _____ E-Mail Address: _____

Phone: _____ ☐ Home ☐ Cell Language(s): _____

Date of Birth: _____ Gender: _____

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Are you now caring for an IHSS recipient or an IHSS applicant? YES ☐ NO ☐ If yes, who? _____

Have you ever cared for an IHSS recipient or applicant? YES ☐ NO ☐ If yes, who? _____

Education

High School: ☐Yes ☐ No Grade Complete: _____

College: ☐Yes ☐ No Major:_____ Degree:_____

Vocational: ☐Yes ☐ No Couse of Study: _____

Certificates

I have a Certificate in:	**Expiration Date**
☐ First Aid	___/___/___
☐ CPR	___/___/___
☐ CNA (Certified Nursing Assistant)	___/___/___
☐ CHHA (Certified Home Health Aid)	___/___/___
☐ HHC (Home Health Certification)	___/___/___

Availability

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Mornings	☐	☐	☐	☐	☐	☐	☐
Afternoons	☐	☐	☐	☐	☐	☐	☐
Evenings	☐	☐	☐	☐	☐	☐	☐
Overnights	☐	☐	☐	☐	☐	☐	☐

Areas Willing to Work

☐ North Stockton
☐ South Stockton
☐ Central Stockton
☐ East Stockton
☐ West Stockton
☐ Manteca/Escalon
☐ Ripon
☐ Lathrop/French Camp
☐ Tracy
☐ Lodi
☐ Linden
☐ Other:_____

Tasks Willing to Perform

Domestic

- ☐ **Teach and demonstrate** the consumer to perform tasks
- ☐ **Paramedical services** injections, feeding tube, etc. tasks taught by professional
- ☐ **Reading**
- ☐ **Clerical**
- ☐ **Domestic services** cleaning house
- ☐ **Preparation of meals**
- ☐ **Meal clean up** cleaning dishes and food after meal
- ☐ **Routine laundry** washing/drying clothes, etc.
- ☐ **Shopping for food**
- ☐ **Other shopping and errands**
- ☐ **Heavy cleaning** thorough cleaning (1 time service)
- ☐ **Accompaniment to medical appointment**
- ☐ **Accompaniment to alternative resources**
- ☐ **Protective supervision** of impaired to protect from injury

Personal

- ☐ **Set up/remind meds**
- ☐ **Bowel and bladder care** assist with using the restroom
- ☐ **Routine bed baths**
- ☐ **Menstrual care** external application only
- ☐ **Bathing, oral hygiene, grooming**
- ☐ **Rubbing skin, repositioning** to promote circulation
- ☐ **Care and assistance with prosthesis** assist with glasses, hearing aid, artificial limb, etc.
- ☐ **Medications**
- ☐ **Respiration** assist with and clean breathing machines
- ☐ **Feeding** assist with eating/drinking
- ☐ **Dressing** assist with clothes
- ☐ **Ambulation** assist with walking/moving

Previous Employment

Company: _____ Phone: **(**_____**)** _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: **$**_____ Ending Salary: **$**_____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: _____ Phone: **(**_____**)** _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: **$**_____ Ending Salary: **$**_____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: _____ Phone: **(**_____**)** _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: **$**_____ Ending Salary: **$**_____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

San Joaquin County IHSS Public Authority

Homecare Provider Registry Application

Certificate of Applicant/Permission to release information

I certify that all the information provided in this application is true. I understand that any false information may eliminate me from enrollment in the Homecare Provider Registry.

I understand that my name and phone number(s) may be placed on a list to be given to persons who are seeking assistance in their homes.

I understand that the information on this questionnaire may also be shared with prospective employers without any further notice.

I understand completing this application and getting placed on the Registry does not guarantee me employment.

I further understand that my employer is not San Joaquin In-Home Supportive Services (IHSS) or the San Joaquin County IHSS Public Authority. The IHSS client is my employer. The San Joaquin County IHSS Public Authority is strictly an "employer of record" for purposes of collective bargaining. I understand that no oral or written agreement may supersede or alter this relationship.

I, _____, authorize all individuals: former employers,
Print Full Your Name

present employer, education institutions, military services, and law enforcement agencies to provide information they may have about me to San Joaquin country IHSS Public Authority.

Signature_____ Date_____
Registry Applicant

Employer Reference Questionnaire

To: _____
Reference's Name

I, _____, do hereby consent to your release of information relating to my
Applicant's Name
employment. I further consent to you or your designated representative to respond to written or telephonic inquiries from the IHSS Public Authority.

Signature: _____ Date: _____

To whom it may concern:

The above individual is applying to join the In-Home Supportive Services (IHSS) Public Authority Provider Registry. The IHSS Public Authority is a public agency whose mission is to serve the IHSS clientele and providers. We provide a "Registry" of available providers to refer to IHSS recipients who are in need of someone to help care for them. As part of the application process, the applicant must provide references. Below is a short questionnaire for you to complete to fulfill the reference requirement. You have the option of returning this form back to the applicant or emailing your response, at nlinsenbigler@sjgov.org . Thank you and we appreciate your timely response!

Position of person completing the reference: _____

Was this individual employed by your company? _____Yes _____ No

Date Hired: _____ Last date of employment: _____

Job responsibilities: _____

_____

_____

How reliable was this individual?	_____ Very	_____ Somewhat	_____ Not Very
How well did this person work with others?	_____ Very	_____ Somewhat	_____ Not Very
How well did this person work under stress?	_____ Very	_____ Somewhat	_____ Not Very
How well did this person follow instructions?	_____ Very	_____ Somewhat	_____ Not Very
Would you rehire this person?	_____ Yes	_____ No	

Is there any reason you can give why this person should not be giving home care with a person who is elderly, blind or disabled? _____

I certify that the above information is true and accurate to the best of my knowledge. I give the IHSS Public Authority permission to contact me with questions and to clarify answers.

Full Name: _____ Date: _____

Signature: _____ Address: _____

Phone Number: _____ _____

IHSS Public Authority, 24 S. Hunter St. Room 5, Stockton, CA 95202, PH: (800) 491-1996 FAX: (209) 944-8913

Personal Reference Questionnaire

To: _____
Reference's Name

I, _____, do hereby consent to your release of information relating to my
Applicant's Name
employment. I further consent to you or your designated representative to respond to written or telephonic inquiries from the IHSS Public Authority.

Signature: _____ Date: _____

To whom it may concern:

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What is your relationship to the applicant? _____

How long have you known this individual? _____

How reliable is this individual? _____ Very _____ Somewhat _____ Not Very

If you had the opportunity, would you hire this individual? _____ Yes _____ No

Have you ever know him/her to abuse drugs or alcohol? _____ Yes _____ No

If yes, how long ago? _____

Is there any reason you can give why this person should not be doing home care with a person who is elderly, blind or disabled? _____

I certify that the above information is true and accurate to the best of my knowledge. I give the IHSS Public Authority permission to contact me with questions and to clarify answers.

Full Name: _____ Date: _____

Signature: _____ Address: _____

Phone Number: _____ _____

Personal Reference Questionnaire

To: _____
Reference's Name

I, _____, do hereby consent to your release of information relating to my
Applicant's Name
employment. I further consent to you or your designated representative to respond to written or telephonic inquiries from the IHSS Public Authority.

Signature: _____ Date: _____

To whom it may concern:

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Have you ever know him/her to abuse drugs or alcohol? _____ Yes _____ No

If yes, how long ago? _____

Is there any reason you can give why this person should not be doing home care with a person who is elderly, blind or disabled? _____

I certify that the above information is true and accurate to the best of my knowledge. I give the IHSS Public Authority permission to contact me with questions and to clarify answers.

Full Name: _____ Date: _____

Signature: _____ Address: _____

Phone Number: _____ _____