San Benito County
Public Authority Registry

1111 San Felipe Rd., Suite 108
Phone: (831) 634-0784 Fax: (831) 634-0796
PA-IHSS@sanbenitocountyca.gov

Thank you for your interest in joining the San Benito County Public Authority Registry.

Please follow the instructions below to begin your application process:

Submit your completed application by email or in person at: 1111 San Felipe Rd., Suite 108
The entire application process must be completed within 10 business days.
Incomplete applications will not be processed.

The registry application process involves the following steps:

1. **Application Submission:** Complete and submit the application, providing all required information.
2. **Application Review:** Public Authority staff will review to ensure it meets the necessary criteria and requirements.
3. **Application Processing:** If accepted, staff will check references and complete an interview by phone or in-person. After completed, staff will provide you with an online enrollment instructions sheet.
4. **Online Enrollment Process:** Read and sign the required documents; schedule to attend an in-person appointment; print the Live Scan form for your background check (estimated cost: $52-$57).
5. **User Registry Agreement:** At your scheduled in-person appointment, you will receive an agreement.
6. Once your in-person appointment is complete and your background check has cleared, your name will be added to the Registry and be referred to IHSS consumers.

Note: If you have been an active IHSS provider in San Benito County within the past year and have already passed a background check, you may not be required to retake your fingerprints or orientation. Please contact the Public Authority office to confirm your status before processing.

If you already have an IHSS client who wants to hire you, it is not necessary for you to apply to the Registry, unless you are seeking employment with other IHSS consumers.

The Public Authority Registry is a referral service that connects IHSS recipients (consumers) with pre-screened independent providers (IPs). Please note: Registration does not guarantee employment. The IHSS consumer is the employer and is solely responsible for finding, interviewing, hiring, training, supervising, and terminating their provider.

Please keep this page for your information

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REGISTRY APPLICATION FOR PROVIDER

***First Name**	**Preferred Name**	***Last Name**
***Home Address**	**City/State**	**Zip Code**
Mailing Address (If different from above)	**City/State**	**Zip Code**
***Cell Phone**	***Email**	

GENERAL INFORMATION

***Gender** ☐ **Male** ☐ **Female**	***Date of Birth**	***SS#**
Monthly Check-In Reminder via E-Mail? ☐ **Yes** ☐ **No**	**Monthly Check-In Reminder via Text Messaging?** ☐ **Yes** ☐ **No**	
I have been providing caregiving services since:		

GOVERNMENT-ISSUED IDENTIFICATION

***I have a Driver's License #:**	**CA Government-Issued ID #:**	***Expiration Date:**

LANGUAGE

***Primary Language Spoken**	**Other:** ☐	☐ **English**	☐ **Spanish**
Secondary Language Spoken	**Other:** ☐	☐ **English**	☐ **Spanish**
***Primary Language Written**	**Other:** ☐	☐ **English**	☐ **Spanish**

CONTACTS

***First Name**	**Middle Initial**	***Last Name**
***Relationship to Provider**	***Emergency Contact** ☐ **Yes** ☐ **No**	
***Cell Phone**	***Email**	

PROVIDER IS WILLING TO WORK WITH THESE SPECIAL REQUIREMENTS

☐	Adults with Developmental Disabilities: Autism, Brain Injury, Cerebral Palsy, Epilepsy, etc.	☐	Adults with Physical Disabilities
☐	Alzheimer's or Dementia	☐	Blind/Vision Impaired
☐	Child/Minor with Developmental Disabilities: Autism, Brain Injury, Cerebral Palsy, Epilepsy, etc.	☐	Child/Minor with Physical Disabilities
☐	Contagious Disease (Infectious Disease or Communicable Disease Easily Transmitted by Physical Contact or Proximity)	☐	State of Emergency
☐	Deaf/Hearing Impaired	☐	Elderly
☐	Hospice Care	☐	Memory Problems
☐	Mental Health Issues: Bi-Polar, Hoarding, OCD Obsessive Compulsive Disorder, Schizophrenia, etc.	☐	Quadriplegic
☐	Scent-Free		Speech Impairment/Unable to Speak

Smoking: ☐ No Preference If there is Smoking or Not	**Smoking:** ☐ There Is No Smoking	**Smoking:** ☐ There Is Smoking Inside & Outside	**Smoking:** ☐ There Is Smoking Outside Only

PROVIDERS CAN MEET THESE NEEDS

☐	Car/Vehicle: Equipped with Ramp/Lift	☐	Car/Vehicle: Standard Passenger Vehicle
☐	Read & Write English	☐	Scheduling Needs: Emergency/Back-Up Provider
☐	Scheduling Needs: Holidays	☐	Scheduling Needs: Live-In Assignment
☐	Scheduling Needs: Short-Term Respite Assignment	☐	Scheduling Needs: Urgent Care
☐	Transfers: Can Transfer Obese Consumers	☐	Transfers: Gait Belt Transfer
☐	Transfers: Hoyer Lift Transfer	☐	Transfers: Pivot Transfer
☐	Transfers: Sliding Board Transfer	☐	Work with Diabetics
☐ ☐	**Smoking:** Provider Must Be a Non-Smoker Provider Is Allowed to Smoke While Working	☐ ☐	Provider Can Be a Smoker but Must Not Smoke While Working, Smoking Outside During Breaks is Ok Provider Can Be a Smoker but Must Not Smoke While Working or During Breaks

PREFERRED CONSUMER GENDER

☐ **No Preference** ☐ **Yes:** ☐ **Female** ☐ **Male** ☐ **Either**

PROVIDER IS OK WITH THESE ANIMALS

☐ **Birds (Caged)** ☐ **Cats** ☐ **Dogs**
☐ **Reptiles (Caged)** ☐ **Other**

PROVIDER SPEAKS THESE LANGUAGES

☐ **English** ☐ **Spanish** ☐ **Other:**

PROVIDER HAS THESE LICENSES & CERTIFICATES

☐ **CNA** ☐ **CPR** ☐ **FIRST AID** ☐ **EMT** ☐ **RN** ☐ **RNA** ☐ **TB TEST CERTIFICATE**

GENERAL AREAS – Please check the cities where you are willing to work:

☐ **Aromas** ☐ **Hollister** ☐ **Paicines** ☐ **Panoche** ☐ **San Juan Bautista** ☐ **Tres Pinos** ☐ **New Idria**

PROVIDER IS WILLING TO PROVIDE THESE SERVICES

☐	Domestic Services (basic house cleaning – sweep, mop, vacuum, dust, etc.	☐	Transfer ☐ Hoyer Lift ☐ Slide Board ☐ other:
☐	Preparation of Meals	☐	Bathing, Oral Hygiene, and Grooming
☐	Meal Clean Up	☐	Rubbing Skin/Repositioning (legs/foot massages, assist with range of motion exercises
☐	Laundry	☐	Care & Assistance with Prosthesis (assist with hearing aids, prosthetic limbs)
☐	Shopping for Food	☐	Accompaniment to Medical Appointments
☐	Other Shopping/Errands	☐	Accompaniment to Alternative Resources
☐	Respiration	☐	Protective Supervision
☐	Bowel & Bladder Care (assist with using restroom, changing diapers, etc.)	☐	Paramedical Services
☐	Feeding (assist client with eating meals)	☐	Heavy Cleaning
☐	Routine Bed Baths	☐	Yard Hazard Abatement
☐	Dressing (put on/take off clothes, shoes	☐	Removal of Snow, Ice
☐	Menstrual Care	☐	Teaching & Demonstration (Assist with Medications (set up medications, remind clients to take medication)
☐	Ambulation (assist with walking/moving about)		

GENERAL AVAILABILITY

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Early Morning (6am-8am)	☐	☐	☐	☐	☐	☐	☐
Morning (8am – 10am)	☐	☐	☐	☐	☐	☐	☐
Late Morning (10am – 12pm)	☐	☐	☐	☐	☐	☐	☐
Noon hour (12pm – 1pm)	☐	☐	☐	☐	☐	☐	☐
Afternoon (1pm – 3pm)	☐	☐	☐	☐	☐	☐	☐
Late Afternoon (3pm – 5pm)	☐	☐	☐	☐	☐	☐	☐
Evening (5pm – 7pm)	☐	☐	☐	☐	☐	☐	☐
Late Evening (7pm – 9pm)	☐	☐	☐	☐	☐	☐	☐
Night (9pm – 11pm)	☐	☐	☐	☐	☐	☐	☐
Late Night (11pm – 1am)	☐	☐	☐	☐	☐	☐	☐
Overnight (12am – 8am)	☐	☐	☐	☐	☐	☐	☐

EMERGENCY/ BACK-UP PROVIDER AVAILABILITY

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Early Morning (6am-8am)	☐	☐	☐	☐	☐	☐	☐
Morning (8am – 10am)	☐	☐	☐	☐	☐	☐	☐
Late Morning (10am – 12pm)	☐	☐	☐	☐	☐	☐	☐
Noon hour (12pm – 1pm)	☐	☐	☐	☐	☐	☐	☐
Afternoon (1pm – 3pm)	☐	☐	☐	☐	☐	☐	☐
Late Afternoon (3pm – 5pm)	☐	☐	☐	☐	☐	☐	☐
Evening (5pm – 7pm)	☐	☐	☐	☐	☐	☐	☐
Late Evening (7pm – 9pm)	☐	☐	☐	☐	☐	☐	☐
Night (9pm – 11pm)	☐	☐	☐	☐	☐	☐	☐
Late Night (11pm – 1am)	☐	☐	☐	☐	☐	☐	☐
Overnight (12am – 8am)	☐	☐	☐	☐	☐	☐	☐

How many hours can you work per week? _____.

Are you interested in being on our Emergency/Back-Up List? Yes ☐ No ☐

How many years of experience do you have in home care services? _____.

How did you hear about us? _____.

Please list any training you have received related to in-home care:

_____

Have you been convicted of a misdemeanor or felony within the past 10 years?

If yes, please note that each case is reviewed individually; therefore, placement on the registry is not guaranteed.

***Note: All applicants will be processed through a criminal background check.**

WORK REFERENCES*: (This section is required - Do not leave it blank.)*
Please list your work or volunteer experience from the past five (5) years, starting with the most recent. We will contact the individuals you list below.

1	Employer Name:	Employment Dates:
	Supervisor Name:	Supervisor Phone:
	Job Responsibilities:	
	Reason for Leaving:	

2	Employer Name:	Employment Dates:
	Supervisor Name:	Supervisor Phone:
	Job Responsibilities:	
	Reason for Leaving:	

3	Employer Name:	Employment Dates:
	Supervisor Name:	Supervisor Phone:
	Job Responsibilities:	
	Reason for Leaving:	

Please provide <u>two</u> personal references who we may contact. <u>Do not</u> use family members.

1	Full Name:	Contact Phone:
	What is your relationship with this person?	
	How long have you known this person?	

2	Full Name:	Contact Phone:
	What is your relationship with this person?	
	How long have you known this person?	

I, _____ hereby certify that, to the best of my knowledge, all information provided in this application is true and accurate. I understand that any false or misleading information may result in denial of enrollment in the Registry. I also understand that any misrepresentation or omission of facts may lead to removal from the Registry.

I acknowledge that maintaining a clear background check is required to remain eligible for the Registry.

I authorize my name and contact information to be shared with IHSS consumers seeking home assistance, and I understand that the references I provide may be contacted.

I further understand that my IHSS consumer is considered my *employer* for the purposes of interviewing, hiring, training, supervision, and termination. San Benito County, the In-Home Supportive Services (IHSS) Program, and the Public Authority are not considered my employer.

Applicant Signature:	**Date:**