Providing Care Home Care

Office Use Only	
Provider #:	
☐ Career ☐ Exclusive ☐ Restricted	

Please print (use blue or black ink), sign, and date application.

1. Personal Information

Name: (Last/First/Middle Initial) (*As shown on your Social Security card.*)	Date of Birth:
Other names used, including maiden and nicknames:	Email address: (Optional)

Street Address:	**Mailing Address:** *(If different than Street Address)*
Street	Street or PO Box
City, State, Zip	City, State, Zip

Your phone number(s) Home:	Cell:	Message:

2. Specific Client – Employer – New Homecare Workers Only

Have you already agreed to work for a particular client-employer? ☐ Yes ☐ No

If yes, please include the name of the individual: _____

Are you willing to work for other client-employers? Now? ☐ Yes ☐ No In the future? ☐ Yes ☐ No

3. Orientation and Certified Training

Have you attended a Homecare Worker Orientation? ☐ Yes ☐ No

If yes, where did you take it? _____ Date, if known _____

Are you CPR Certified?
☐ Yes ☐ No If yes, when does it expire? _____

Are you First Aid Certified?
☐ Yes ☐ No If yes, when does it expire? _____

You must present your card(s)

4. Transportation

What kind of transportation do you use to get to work? (Check all that apply)

☐ Motor Vehicle ☐ Public Transportation ☐ Bike/Walk

Are you willing to: (Check all that apply)

Transport an employer in your car?	☐ Yes	☐ No
Drive an employer's car?	☐ Yes	☐ No
Escort an employer on public transportation?	☐ Yes	☐ No
Escort an employer in their car?	☐ Yes	☐ No

5. Language - In Order of Ability

What languages, including Sign Language, do you speak and/or read?

1. _____ ☐ Speak ☐ Read
2. _____ ☐ Speak ☐ Read
3. _____ ☐ Speak ☐ Read
4. _____ ☐ Speak ☐ Read

Please provide your Live Scan Result

Name: (Last/First/Middle Initial) (*As shown on your Social Security card.*)	Date of Birth:

6. Availability to Work

Are you currently looking for work? __ Yes ☐ No

Check all work types you are willing to consider:

- ☐ Full-time (over 20 hours per week)
- ☐ Part-time (20 hours per week or less)
- ☐ Being a live-in (24 hour service)
- ☐ Providing live-in relief
- ☐ Providing substitute services paid by the hour
- ☐ Working with short notice

7. Work Schedule

Check the days/times you are available for work.

If you are available at all times check here ☐

Weekday	Mornings	Afternoons	Evenings	Nights
Monday	☐	☐	☐	☐
Tuesday	☐	☐	☐	☐
Wednesday	☐	☐	☐	☐
Thursday	☐	☐	☐	☐
Friday	☐	☐	☐	☐
Saturday	☐	☐	☐	☐
Sunday	☐	☐	☐	☐
Holidays	☐	☐	☐	☐

8. Services and Work Experience

Check all of the services below that you are **"Willing"** to provide. In addition, if you have **"Experience"** in any of these tasks, please check the **"Experience"** column. You must be physically able to perform all the services you check in this section. ***DO NOT check any tasks where you have physical limitations (such as lifting, bending or stooping) that would prevent you from performing any of these services.***

Activities of Daily Living	Willing	Experience
Ambulation	☐	☐
Bathing	☐	☐
Dressing	☐	☐
Feeding	☐	☐
Grooming	☐	☐
Personal Hygiene	☐	☐
Positioning	☐	☐
Toileting	☐	☐
Transferring	☐	☐

Name: (Last/First/Middle Initial) (*As shown on your Social Security card.*)	Date of Birth:

8. Services and Work Experience Continued

Check all of the services below that you are **"Willing"** to provide. In addition, if you have **"Experience"** in any of these tasks, please check the **"Experience"** column. You must be physically able to perform all the services you check in this section. ***DO NOT check any tasks where you have physical limitations (such as lifting, bending or stooping) that would prevent you from performing any of these services.***

Self – Management Tasks	**Willing**	**Experience**
Giving or setting up medications	☐	☐
Housekeeping	☐	☐
Laundry	☐	☐
Meal preparation	☐	☐
Shopping	☐	☐
Transportation	☐	☐

Companionship - Socialization Service	**Willing**	**Experience**
Outside/Gardening	☐	☐
Evening/Morning walks	☐	☐
Hair dresser appointments	☐	☐
Senior group meetings	☐	☐
Church outings	☐	☐
Computer/new technology skills	☐	☐
Letter writing/Reading	☐	☐
Playing games	☐	☐
Reading a book aloud	☐	☐
Respite day/night	☐	☐

9. Additional Information

Your gender: ☐ Female ☐ Male

Do you smoke? ☐ Yes ☐ No If you smoke, are you willing to smoke outside? ☐ Yes ☐ No

Are there employers you are **NOT** willing to work with or services you are **NOT** willing to provide?

(Check all that apply)		
	☐ Activities of Daily Living (see page 2)	☐ Self-Management Tasks (see above)
	☐ Alzheimer's or other dementias	☐ 65 years of age or older
	☐ Behavioral disorders	☐ Smokers
	☐ Females	☐ Terminally ill
	☐ Males	☐ Under 65 years of age
	☐ People with pets	☐ Using medical marijuana

Name: (Last/First/Middle Initial) (*As shown on your Social Security card.*)	Date of Birth:

10. Caregiver References:

Please list two people you have provided care for in the past. (Name, Duration of Care, Tel.*)

Education History: _____

11. Abuse Investigation

Have you ever been investigated for abuse, neglect or domestic violence? ☐ Yes ☐ No

If yes, please explain: _____

12. Applicant Certification

I certify that all information I supplied in this application is accurate to the best of my knowledge. I understand that should I knowingly misrepresent information may result in rejection of my application

Providing Care Home Care, (PCHC) assist seniors and individuals with disabilities find qualified in-home providers. I understand that if I agree to be referred to prospective client-employers through the **PCHC** my contact information, (name, phone number and provider number) will be released to anyone seeking in-home services.

- I agree to have my contact information released through the PCHC ☐ Yes ☐ No
  I understand that checking "No" will limit the number of referrals I will receive.
- If yes, I agree to have my contact information referred to individuals who pay privately for in-home services.
  I understand the hours worked for individuals who pay privately for services DO NOT count toward Service Employees and may not have worker's compensation or unemployment insurance.
  ☐ Yes ☐ No

Furthermore, I understand it is my responsibility to keep my availability information updated, and I must review my information with **PCHC** at least one time every 60 days to continue to be referred for new jobs.

Applicant Signature: _____ Date: _____

Name: (Last/First/Middle Initial) (*As shown on your Social Security card.*)	Date of Birth:

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Branch office where application was submitted: _____

I-9 Form completed? ☐ Yes

Is Provider 18 years of age or older? ☐ Yes

W-4 Form completed? ☐ Yes

DHS 0301 Form completed and submitted to local office? ☐ Yes Date submitted _____

SDS 0356 signed and witnessed? ☐ Yes

If CPR Certified, expiration date verified? ☐ Yes Expiration date _____

If First Aid Certified, expiration date verified? ☐ Yes Expiration date _____

Fingerprints requested from HCW? ☐ Yes Date requested _____

Fingerprints received from HCW? ☐ Yes Date received _____

Fingerprints submitted to Salem? ☐ Yes Date submitted _____

Fingerprints returned from Salem? ☐ Yes Date returned: _____

Initial Criminal History Fitness Determination Clearance? ☐ Yes

SDS 0736 Form, Enrollment form completed? ☐ Yes

Orientation verified? ☐ Yes Date completed: _____

Abuse investigation noted on application? ☐ Yes

Application Status: ☐ Approved ☐ Closed ☐ Denied ☐ Voluntary withdrawal

Provider Number: _____

If denied at initial application, indicate date: _____ Reason for denial: _____

Approved to work with PCHC / Independent contractor? ☐ Yes