



NAPA COUNTY

PUBLIC AUTHORITY
IN-HOME SUPPORTIVE SERVICES
 650 IMPERIAL WAY SUITE 101 NAPA, CA 94559

(707) 259-8359

EMAIL: IHSSPUBLICAUTHORITY@COUNTYOFNAPA.ORG

APPLICATIONS WILL NOT BE CONSIDERED UNLESS COMPLETELY FILLED OUT

I. PERSONAL INFORMATION:

FIRST NAME:		LAST NAME:	
ADDRESS:		CELL PHONE:	
CITY/STATE:		HOME PHONE:	
POSTAL CODE:		PRIMARY EMAIL:	
Mailing Address if different from physical address:		DATE OF BIRTH:	
GENDER	<input type="checkbox"/> Male Female	ID/DL#	EXPIRATION DATE:
Social Security #		State Issued	
DO YOU HAVE AUTO INSURANCE?	Yes No	If yes, indicate name of your insurance carrier:	
How did you hear about being on the registry?			
Case Manger/Social Worker Internet	<input type="checkbox"/> Employment Office <input type="checkbox"/> Word of Mouth	Flyer/Mailer/Newsletter Other: _____	Independent Living Center

II. WORK AVAILABILITY:

Please check off the days/times you are willing to work:

	Mondays	Tuesdays	Wednesday	Thursdays	Fridays	Saturdays	Sundays
MORNINGS	<input type="checkbox"/>						
AFTERNOONS	<input type="checkbox"/>						
EVENINGS	<input type="checkbox"/>						
Hours you want to work each week:	_____						

III. GEOGRAPHIC AREAS: Please check the areas where you are willing to work. **NOTE:** Checking more boxes does not necessarily mean you will be referred out more often.

<input type="checkbox"/> AMERICAN CANYON	<input type="checkbox"/> LAKE BERRYESSA	<input type="checkbox"/> POPE VALLEY
<input type="checkbox"/> ANGWIN	<input type="checkbox"/> NAPA	<input type="checkbox"/> YOUNTVILLE
<input type="checkbox"/> CALISTOGA	<input type="checkbox"/> ST. HELENA	

IV. TYPE OF WORK DESIRED: *The following information will be used for the purpose of matching in home supportive services recipients to providers.*

<p>Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will you work with a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will you work with pets? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Form of transportation _____</p> <p>Would you use your car to transport a client? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Would you drive the client's car? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you read/write English? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Please check off which of the following tasks you are willing to perform or learn:

<input type="checkbox"/> Domestic Services <input type="checkbox"/> Preparation of Meals <input type="checkbox"/> Meal Clean-Up <input type="checkbox"/> Laundry <input type="checkbox"/> Shopping for food <input type="checkbox"/> Other shopping/errands <input type="checkbox"/> Respiration <input type="checkbox"/> Bowel and Bladder Care <input type="checkbox"/> Feeding <input type="checkbox"/> Routine Bed Bath <input type="checkbox"/> Dressing <input type="checkbox"/> Menstrual Care	<input type="checkbox"/> Ambulation <input type="checkbox"/> Transfer <input type="checkbox"/> Bathing, Oral Hygiene, and Grooming <input type="checkbox"/> Rubbing Skin, Repositioning <input type="checkbox"/> Care & Assistance with Prostheses <input type="checkbox"/> Accompaniment to Medical Appointments <input type="checkbox"/> Accompaniment to Alternative Resources <input type="checkbox"/> Protective Supervision <input type="checkbox"/> Paramedical Services <input type="checkbox"/> Heavy Cleaning <input type="checkbox"/> Yard Hazard Abatement <input type="checkbox"/> Teaching & Demonstration
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Willing to work with:		
Children	Men	Women

V. GENERAL INFORMATION

What is your ethnicity?		
African American	Asian-Pacific Islander	Caucasian
Native American	Latino / Hispanic	Other _____
Which languages do you speak fluently?		
English	Other _____	
Spanish	Primary Language: _____	

Have you ever been convicted of a felony or misdemeanor?	
Yes	No
<i>If yes, explain:</i> _____	
Do you give the Public Authority permission to conduct a background check?	
Yes	No

V. GENERAL INFORMATION cont.

List any training/experience you have had related to in-home care:

If any, please explain: _____

List any certificates, licenses, and or training related to In-Home care you possess:

First Aid Expires: _____

CNA Expires: _____

CPR Expires: _____

Other: _____

Resume is not accepted in place of a completed application

VI. WORK EXPERIENCE: *If you have letters of recommendation, resumes, or any additional forms, please staple to application.*

Please list your work experience, beginning with your most recent employer.

Employment Dates: _____ to _____ May we contact? Yes No

Employer: _____ Related Duties: _____

Address: _____

City, State, Zip: _____ Phone #: _____

Reason for Leaving: _____

Supervisor's Name: _____ Supervisor's #: _____

Employment Dates: _____ to _____ May we contact? Yes No

Employer: _____ Related Duties: _____

Address: _____

City, State, Zip: _____ Phone#: _____

Reason for Leaving: _____

Supervisor's Name: _____ Supervisor's #: _____

Employment Dates: _____ to _____ May we contact? Yes No

Employer: _____ Related Duties: _____

Address: _____

City, State, Zip: _____ Phone#: _____

Reason for Leaving: _____

Supervisor's Name: _____ Supervisor's #: _____

VII. PERSONAL REFERENCES: *Please list three people you know personally whom we can contact as references. Please do not list family members*

1. Name: _____ Home Phone: _____

Relation: _____ Work Phone: _____

How long have you known this person? : _____

2. Name: _____ Home Phone: _____

Relation: _____ Work Phone: _____

How long have you known this person? : _____

3. Name: _____ Home Phone: _____

Relation: _____ Work Phone: _____

How long have you known this person? : _____

Resumes and Letters of reference are OPTIONAL but may be submitted as supplemental to this application, please read below

PERSONAL REFERENCE TEMPLATE (OPTIONAL)

Must be legible and include the following:

- First and last name
- Address
- Phone number
- Email address
- How long has the person known the applicant (must be at least 6 months)
- Their relationship to applicant (friend, former boss, teacher, etc.) (Cannot be a relative)
- A few brief sentences regarding the character of the applicant
- The best time for Registry staff to contact the reference (time must be between the hours of 8-5 Monday thru Friday)
- Signature
- The date of the reference letter

PROFESSIONAL REFERENCE TEMPLATE (OPTIONAL)

Must be legible and include the following:

- Name of the IHSS Consumer, private client, supervisor, etc.
- Address
- Phone number
- Email address
- How long has the applicant worked for the Consumer or employer (specify dates); (must be at least 6 months)
- What services was the applicant providing the client or what job duties did they have at the employer
- Best time for Registry staff to contact reference (time must be between the hours of 8-5 Monday thru Friday)
- Signature
- The date of the reference letter

I certify that the information provided on this application is true and correct and to the best of my knowledge. I understand that providing any false information may disqualify me from enrollment and that all information provided is subject to verification.

I understand that my name and phone number 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 application may also be shared with prospective employers.

I understand that the Napa County IHSS Public Authority asks for personal information from me for the purpose of matching recipients to providers, and that I will not be discriminated against due to my age or ethnicity.

I also understand that the IHSS recipient is my employer, and not the Napa County IHSS Public Authority.

Signature

Date

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