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	☐ 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 ☐ Employment Office ☐ Flyer/Mailer/Newsletter ☐ Independent Living Center
☐ Internet ☐ Word of Mouth ☐ Other: _____

II. WORK AVAILABILITY:

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

	Mondays	Tuesdays	Wednesday	Thursdays	Fridays	Saturdays	Sundays
MORNINGS	☐	☐	☐	☐	☐	☐	☐
AFTERNOONS	☐	☐	☐	☐	☐	☐	☐
EVENINGS	☐	☐	☐	☐	☐	☐	☐

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.*

☐ AMERICAN CANYON
☐ ANGWIN
☐ CALISTOGA
☐ LAKE BERRYESSA
☐ NAPA
☐ ST. HELENA
☐ POPE VALLEY
☐ YOUNTVILLE

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

Do you smoke? ☐ Yes ☐ No **Will you work with a smoker?** ☐ Yes ☐ No **Will you work with pets?** ☐ Yes ☐ No	**Form of transportation**_____ **Would you use your car to transport a client?** ☐ Yes ☐ No **Would you drive the client's car?** ☐ Yes ☐ No **Do you read/write English?** ☐ Yes ☐ No

Please check off which of the following tasks you are willing to perform or learn:

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

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

If yes, explain: _____

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