

Approved: Yes No
 Approved By: _____
 Approval Date: _____

PASC Homecare Registry

REGISTRY APPLICATION FORM FOR PROVIDERS

First Name: _____	Last Name: _____	Middle Initial: _____
IHSS Provider Number: _____		

Home Phone: (____)____-____ **Cell Phone:** (____)____-____

By checking this box, you are allowing PASC to send you automated text messages and calls to the phone number you have provided. At anytime if you decide you no longer want to receive the information from PASC via text or phone, you can email "Stop" to info@pascla.org. Make sure to include the phone number you are opting out. Standard messaging rates may apply.

Message Phone: (____)____-____ **Email Address:** _____

Home Address: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip:** _____

Gender: Male Female Other _____

Date of Birth: _____

List the names and phone numbers of two people we can contact in case of an emergency relating to your health.

Emergency Contact 1: _____ **Phone** _____

Emergency Contact 2: _____ **Phone** _____

What language(s) do you speak? 1: _____ **2:** _____

3. Sign Language: _____ **Other:** _____

Do you plan on moving to another state or county within the next few months?

Yes, When? _____ No

Race/Ethnic Group: (Optional - This information is collected only for statistical reasons. It is not used for matching or assignments.)

Please check the tasks you are capable of and willing to perform for the recipient.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Domestic Services | <input type="checkbox"/> Remove Grass, Weeds, Rubbish | <input type="checkbox"/> Bowel & Bladder Care | <input type="checkbox"/> Care & Assistance With Prosthesis |
| <input type="checkbox"/> Preparation of Meals | <input type="checkbox"/> Remove Ice, Snow | <input type="checkbox"/> Feeding | <input type="checkbox"/> Set Up, Remind Meds |
| <input type="checkbox"/> Meal Clean Up | <input type="checkbox"/> Shopping for Foods | <input type="checkbox"/> Routine Bed Baths | <input type="checkbox"/> Catheter/Colostomy Bag |
| <input type="checkbox"/> Routine Laundry | <input type="checkbox"/> Protective Supervision | <input type="checkbox"/> Dressing | <input type="checkbox"/> Diapers |
| <input type="checkbox"/> Shopping for Food | <input type="checkbox"/> Teaching & Demonstration | <input type="checkbox"/> Menstrual Care | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Other Shopping & Errands | <input type="checkbox"/> Paramedical Services | <input type="checkbox"/> Ambulation | <input type="checkbox"/> Hoyer Lift |
| <input type="checkbox"/> Heavy Cleaning | <input type="checkbox"/> Willing to use your own car | <input type="checkbox"/> Moving In/Out of Bed | <input type="checkbox"/> Lifting/Transfer |
| <input type="checkbox"/> Accompany to Dr. App't | <input type="checkbox"/> Respiration | <input type="checkbox"/> Bathing, Oral Hygiene | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Accompany to Alternative Resources | | <input type="checkbox"/> Grooming | <input type="checkbox"/> Toileting |
| | | <input type="checkbox"/> Rubbing Skin, Repositioning | <input type="checkbox"/> Vital Signs |
| | | | <input type="checkbox"/> Wheelchair Assistance |
| | | | <input type="checkbox"/> Prosthetic Assistance |

Have you had experience and/or training in any of the following? (Check all that apply.)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Range of Motion | <input type="checkbox"/> Traumatic Brain injury |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Respiration Assistance | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Bowel Program | <input type="checkbox"/> Insulin Care | <input type="checkbox"/> Seizures | <input type="checkbox"/> Feeding Tubes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental/Emotional Disability | <input type="checkbox"/> Special Diet | <input type="checkbox"/> Wound Care |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Lifting Devices/ Hoyer Lift |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Ventilators |

**Are you certified in any of the following areas? (Check all that apply)
You will be asked to present certification documents.**

- | | | | |
|------------------------------------|--|--|---|
| <input type="checkbox"/> First Aid | <input type="checkbox"/> Certified Nursing Assistant (CNA) | <input type="checkbox"/> Home Care Worker Training | <input type="checkbox"/> Vocational Nurse (LVN) |
| <input type="checkbox"/> CPR | <input type="checkbox"/> Registered Nurse (RN) | | <input type="checkbox"/> Home Health Aide |

Years of experience in homecare or similar work: _____

Are you willing to not use perfume or other scented fragrances on the job?

Yes No

Are you willing to work for a recipient that has a dog? Yes No

Are you willing to work for a recipient that has a cat? Yes No

Are you willing to work at a home where smoking is practiced?

Yes No

Are you willing to comply with a no-smoking rule at your recipient's home? Yes No

Do you have a driver license? Yes No

Do you plan on driving to work? Yes No

Are you currently working as an IHSS Provider? Yes No

If YES, how many IHSS hours are you currently working per month? _____

How many hours can you work per month? _____

Times of Availability: Flexibility in times you are willing to work gives you an advantage in obtaining referrals. Indicate with a check mark (√) the days and times of day you are willing to work.

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overnight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Live-In	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Areas of Availability: Please list the cities or geographic areas in which you would be willing to work.

References: (Do not include relatives.) Upon request, the Registry will give these references to any of your prospective employers. Please make sure these numbers are valid and these references have given their consent to be contacted in relation to your job search efforts.

Name	Telephone Number	How long have you known this person?

Below is a link to the SOC form 2327 – IHSS Provider’s Right to File a Sexual Harassment Complaint.

https://pascla.org/wp-content/uploads/bsk-pdf-manager/2025/10/SOC-2327-8_25-In-Home-Supportive-Services-IHSS-Providers-Right-to-File-a-Sexual-Harassment-Complaint.pdf

(800) 844-1684

I certify under penalty of perjury that the information provided above is true and complete to the best of my knowledge. I also understand that any misrepresentation on my part may result in disqualification or removal from the PASC Homecare Registry at any time. I further authorize the Registry and/or the recipient to contact the above references concerning my character and I authorize the Registry to share any such information with others for Registry purposes. I waive any claim(s) I may have regarding any such reference information.

X _____
Signature

Date

IMPORTANT -- LEGALLY BINDING AGREEMENT -- REVIEW CAREFULLY**PASC HOMECARE REGISTRY -
IHSS PROVIDER'S SERVICES AND RELEASE AGREEMENT**

If you need assistance in reading or understanding this document, you should obtain the help of a trusted family member, friend or representative.

You intend to use the services of the PASC Homecare Registry. The Registry provides referrals of IHSS homecare Providers to participating Recipients. For certain eligible enrolled Recipients, the Registry also provides referrals of temporary back-up attendants under the PASC Back-up Attendant Program. **The term "Provider" as used in this Agreement covers both regular Providers and also Back-up Attendants.** As a condition for your use of the services of the Registry, the following matters are acknowledged and agreed upon:

- Registry's Limited Role:** PASC operates the Homecare Registry, free of charge to all participants, primarily for the purpose of assisting individual Recipients and Providers to make contact with one another and possibly form an employment relationship. **The Registry does not perform any background checks of the Recipient participants in Registry programs. Nor does the Registry supervise the Recipient or the employment. You therefore must use your own judgment and assume all risks of accepting or engaging in the employment relationship with any Recipient.**
- Recipient is the Employer:** The Recipient has the sole authority to hire, assign duties, supervise, and terminate you, and you have the right to resign from any Recipient's employment. The Registry has no role in such decisions. The provision of paramedical services such as insulin injections and feeding tube assistance by any Provider (including back-up attendants) is solely under the authority of the Recipient and the Recipient's physician, not the Registry. **PASC has no responsibility for employment matters, for any injuries that may arise out of the referral or the employment, or for investigating or resolving any disputes, losses or injuries that may arise between a Provider and Recipient.**
- Availability of Referrals:** The Registry has no control over the nature or volume of Recipient requests for referrals, nor the number of Providers who may be available at any given time, and therefore **the Registry cannot assure the volume of referrals that may be available to Providers at any given time.**
- Criminal Background Checks:** **The statutory authority for determining the standards for disqualification of a prospective or existing IHSS provider is Welfare & Institutions Code (W&IC) Sections 12305.81 and 12305.87.** The Registry abides by prevailing state laws concerning an applicant's eligibility to work as an IHSS Provider. Also, in the event that the Registry learns of a later disqualifying conviction or incarceration, it may report that to the Recipient who is then employing you as a Provider. If any dispute arises concerning the impact of the criminal background check upon a Provider's access to the Registry, it shall be resolved solely under procedures of the Registry Review Committee, and shall not be subject to any further proceedings or litigation of any nature.

- 5. **Reference Checks – Consent and Release:** You hereby consent to PASC and/or any Recipient contacting your prior employers and personal references, and **you hereby release any prior employers and any references from any claims or liabilities arising out of any statements or information they may provide.**
- 6. **Use of Personal Information:** As part of its operations the Registry receives personal information from the Recipient, the County and in some instances third parties about the Recipient’s or Provider’s participation in the IHSS Program. The Registry will use such information only as for Registry purposes. The Registry may also use such information to exclude, suspend, or remove a Registry participant for good cause, through confidential procedures. Any disputes concerning exclusions, suspensions and/or removals from the Registry are subject to review and resolution solely by the Registry Review Committee, whose decisions are final and binding upon all concerned, and are not to be the subject of any further proceedings or litigation of any nature.
- 7. **Provider’s Responsibilities to the Registry:** As an ongoing condition of Registry participation, all Registry participants (Providers and Recipients) must: (a) comply with all Registry policies, procedures and directives, and cooperate fully with Registry personnel; (b) keep the Registry updated as to all decisions regarding referrals; and (c) treat Registry staff and all other Registry participants with civility and respect.(d) Availability Updates: Providers are required to contact PASC at least once every 30 days to update their work availability and employment status. Failure to comply will result in the provider being classified as inactive. Inactive providers will not be referred to recipients until they re-establish contact and provide updated availability and status information. Additionally, all providers must maintain an active and reachable phone number at all times. (e) Referral Radius: Provider referrals will be made based on the geographic proximity to the recipient’s residence. Referrals will occur within a 5-, 10-, or 15-mile radius, depending on availability and recipient needs.
- 8. **Release Agreement:** In consideration for the services to be provided to you by the Registry, you hereby release PASC and Los Angeles County (together with its and their employees, governing boards, agents, insurers, contractors, volunteers, and others who have furnished information or services or otherwise cooperated with PASC) from any claims, damages, injuries, liabilities or remedies of any nature relating in any way to the Registry, its services or denial of services, or its actions or failures to act. This Release is also made on behalf of your personal representatives, family, dependents, heirs and assignees. This Release does not affect any rights or claims you may have either under the PASC-SEIU Agreement, or against the State of California under Workers Compensation or Unemployment Insurance laws.
- 9. **Signature:** The undersigned has carefully reviewed and considered each and every one of the terms and conditions of this entire Agreement, understands them, and voluntarily decided to agree with them. PASC will rely upon this Agreement when granting Registry services to you.

Signature of IHSS Provider/Applicant

Print Name of IHSS Provider/ Applicant

Date

Home Telephone No.

Personal Assistance Services Council



Luis Bravo
Executive Director