In-Home Supportive Services Public Authority San Bernardino County

784 E. Hospitality Lane, San Bernardino, CA 92415-0034
• Toll Free 1 (866) 985-6322 • Fax (909) 927-4176

IHSS-PA CLIENT REGISTRY ASSESSMENT

NAME: _____
Last Name First Name MI

ADDRESS: _____, CA _____
Street City Zip Code

SS#: _____-____-_____ **PHONE:** (_____) _____ **Email:** _____

IHSS CASE #: _____ **IHSS SOCIAL WORKER:** _____ **Phone #:** _____

1. **Are you currently a Molina ☐ or IEHP ☐ member?**
2. **My primary language is:** ☐ English ☐ Spanish Other: _____
3. **Do you smoke?** ☐ Yes ☐ No
4. **Will you hire a provider that is a smoker?** ☐ Yes ☐ No ☐ Preference / under what condition: _____
5. **Do you have pets in your home?** ☐ Yes ☐ No Type _____
6. **Do have any health conditions? If yes, please list.** ☐ Yes ☐ No
   - ☐ Mental Disability Type _____
   - ☐ Infectious Disease Type _____
   - ☐ Developmentally Disabled Type _____
7. **Would you hire a provider with a criminal background history?** ☐ Yes ☐ No
8. **Do you have a car?** ☐ Yes ☐ No ☐ Provider must have a car
9. **Is your home near public transportation?** ☐ Yes ☐ No
10. **Do you live alone?** ☐ Yes ☐ No ☐ If no, please state: _____
11. **Provider gender preference** ☐ Male ☐ Female ☐ No Preference
12. **How do you move throughout your home?**
    ☐ Ambulate (walk) ☐ Bed bound ☐ Use a cane ☐ Use a walker ☐ Use a wheelchair
13. **Do you currently have a provider?** ☐ Yes ☐ No
14. **What are your schedule preferences regarding a provider? (please check all that apply):**
    ☐ Morning ☐ Afternoons ☐ Evenings ☐ Overnights
    ☐ Monday – Friday (Daily) ☐ Monday – Friday (1 – 4 days a week) ☐ Weekends

AUTHORIZATION FOR RELEASE OF INFORMATION

Terms of Use and Release of Information

I understand that the information contained on this application is intended for the exclusive use of the San Bernardino County In-Home Supportive Services Public Authority (Public Authority) for the purpose of providing me a list of referrals of pre-screened IHSS Providers. I understand that my use of Registry Services does not commit me to hiring any individual referred by the Public Authority, nor does it imply a guarantee of satisfaction with the persons referred. I understand that I retain the right to hire, fire and supervise the work of any IHSS Provider referred to me by the Public Authority.

Terms of Personal Release of Information

In order for the Public Authority to obtain from or release to other parties any information about you, Federal and State laws require your specific authorization. Please check all applicable sections below.

I hereby authorize the Public Authority to exchange with:

☐ **IHSS / DAAS** ☐ **Provider** ☐ **Hospital** ☐ **Emergency / Contact**

☐ **Other:** _____

If you have authorized to discuss confidential information, specify the period during which we may communicate with the person's / agencies listed above, by checking the appropriate box below.

☐ **I authorize ongoing communication unless I revoke this consent in writing.**

☐ **I authorize communication only until** _____ **(specify date).**

I understand that I do not have to agree to release confidential information and that I may withdraw this consent at any time in writing, but if I do, it will not have any effect on any actions IHSS Public Authority took before it received the revocation. A facsimile of this form will be regarded as valid as the original.

_____ _____

Client Signature **Date**

_____

Name (printed)

EMERGENCY CONTACT:

NAME	PHONE NUMBER	RELATIONSHIP TO YOU

ASSISTANCE IN COMPLETING THIS APPLICATION WAS PROVIDED BY:

_____ _____ _____

Name Signature Date