



Homecare Worker Application

Seniors and People with Disabilities
Oregon Home Care Commission

Office Use Only	
Provider #:	<input type="text"/>
<input type="checkbox"/> Career	<input type="checkbox"/> Restricted

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

Personal Information 1

Name: (last/first/middle initial) (as shown on your Social Security card.)	Date of birth:
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Other names used, including maiden and nicknames:	E-mail address:
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Street address: Street	Mailing address: (If different than street address) Street or PO Box
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City, State, Zip	City, State, Zip
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Your phone number(s) Home:	Cell:	Message:
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Specific Client – Employer – New Homecare Workers Only 2

Have you already agreed to work for a particular client-employer? Yes No
 If yes, please include the name of the individual: _____

Orientation and Certified Training 3

Have you attended a homecare worker orientation? Yes No
 If yes, where did you take it? _____ Date, if known: _____

Have you attended a live-in 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)

Transportation 4

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drive an employer's car?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Escort an employer on public transportation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Escort an employer in their car?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Language - In Order of Ability 5

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

1. _____ Speak Read 2. _____ Speak Read

3. _____ Speak Read 4. _____ Speak Read

Availability to Work**6**Are you currently looking for work? Yes No

Check all work types you are willing to consider:

- | | |
|--|---|
| <input type="checkbox"/> Full-time (over 20 hours per week) | <input type="checkbox"/> Providing live-in relief |
| <input type="checkbox"/> Part-time (20 hours per week or less) | <input type="checkbox"/> Providing substitute services paid by the hour |
| <input type="checkbox"/> Being a 7 day live-in (24 hour service) | <input type="checkbox"/> Working with short notice |
| <input type="checkbox"/> Being a 6 day live-in (24 hour service) | <input type="checkbox"/> Being a 5 day live-in (24 hour service) |
| <input type="checkbox"/> Being a 2 day live-in (24 hour service) | <input type="checkbox"/> Being a 1 day live-in (24 hour service) |

Would you be willing to assist with evacuation and in-home services in the event of a natural disaster? Yes No**Work Schedule****7**Check the days/times you are available for work. If you are available at all times check here

Weekday	Mornings	Afternoons	Evenings	Nights
Monday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wednesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thursday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Saturday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Holidays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Services and Work Experience**8**

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	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder Care	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel Care	<input type="checkbox"/>	<input type="checkbox"/>	
Cognition	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	
Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	
Positioning	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	

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	<input type="checkbox"/>	<input type="checkbox"/>	
Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	
Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>	
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	

Health – Related Procedures	Willing	Experience	
Bowel program	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding Tube	<input type="checkbox"/>	<input type="checkbox"/>	
Home dialysis	<input type="checkbox"/>	<input type="checkbox"/>	
Injections	<input type="checkbox"/>	<input type="checkbox"/>	
Ostomy care (e.g., colostomy, ileostomy)	<input type="checkbox"/>	<input type="checkbox"/>	
Oxygen management	<input type="checkbox"/>	<input type="checkbox"/>	
Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	
Tracheotomy care	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary catheter care	<input type="checkbox"/>	<input type="checkbox"/>	
Ventilator care	<input type="checkbox"/>	<input type="checkbox"/>	
Wound care	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Information

Your gender: Female Male

Do you smoke? Yes No

Do you want to receive quit smoking information and/or materials via E-mail? Yes No

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

(Check all that apply)	<input type="checkbox"/> Activities of daily living (see page 2)	<input type="checkbox"/> Self-management tasks (see above)
	<input type="checkbox"/> Alzheimer’s or other dementias	<input type="checkbox"/> 65 years of age or older
	<input type="checkbox"/> Behavioral disorders	<input type="checkbox"/> Smokers
	<input type="checkbox"/> Females	<input type="checkbox"/> Terminally ill
	<input type="checkbox"/> Males	<input type="checkbox"/> Under 65 years of age
	<input type="checkbox"/> People with pets	<input type="checkbox"/> Individuals that use medical marijuana

Geographical Location**10**

Where are you willing to work? (*Select a maximum of three counties.*)

Counties:

Cities:/areas within the counties:

Abuse Investigation**11**

Have you ever been investigated for abuse, neglect or domestic violence?

 Yes No

If yes, please explain: _____

Minimum Qualifications for Homecare Workers (HCW's)**12**

An individual who would like to be a HCW must meet the following minimum qualifications:

Submit a completed application packet.

- (1) Pass a DHS criminal history clearance and cooperate with a criminal history re-check when requested.
- (2) Complete a HCW orientation within 90 days. Complete a live-in orientation if applicable.
- (3) Be capable of providing or learning to provide necessary services.
- (4) Be 18 years of age or older (age exceptions may be made on a case-by-case basis for family members only, but exceptions will not be granted for anyone under the age of 16).

An individual who would like to be a career HCW and be referred to the general public to provide homecare services through the Registry and Referral System (RRS) must meet the requirements listed above, plus the following:

- (1) Be 18 years of age or older (no exceptions).
- (2) Disclose qualifications, skills (including language skills), and experience that can be verified and evaluated by a potential client-employer, as well as submit references upon request.
- (3) Disclose any job related limitations.
- (4) Review and update homecare worker information in the RRS at least every 60 days, if looking for work.
- (5) Immediately notify the local SPD/AAA office or the Oregon Home Care Commission of address and phone number changes.

Applicant Certification**13**

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 and/or denial of placement on the Oregon Home Care Commission (OHCC) Registry and Referral System (RRS). I understand and agree to the minimum qualifications for homecare workers established by the OHCC.

The OHCC has an internet-based registry to 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 RRS, my contact information, (name, phone number, provider number and city of residence) will be released to anyone seeking in-home services.

Future changes to the following questions must be submitted in writing to the local office.

- A. I agree to have my contact information released through the internet. Yes No
I understand that checking "No" will limit the number of referrals I will receive.
- B. I agree to have my contact information referred to individuals who pay privately for in-home services. Yes No

I understand the hours worked for individuals who pay privately for services DO NOT count towards Service Employees International Union (SEIU) local 503, Oregon Public Employees Union (OPEU) negotiated benefits and may not have worker's compensation or unemployment insurance.

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

Applicant Signature: _____

Date: _____

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Branch office where application was submitted:

I-9 form completed?	<input type="checkbox"/> Yes	
Is provider 18 years of age or older?	<input type="checkbox"/> Yes	
W-4 form completed?	<input type="checkbox"/> Yes	
DHS 0301 form completed and submitted to local office?	<input type="checkbox"/> Yes	Date submitted / /
SDS 0356 signed and witnessed?	<input type="checkbox"/> Yes	
If CPR certified, expiration date verified?	<input type="checkbox"/> Yes	Expiration date / /
If first aid certified, expiration date verified?	<input type="checkbox"/> Yes	Expiration date / /
Fingerprints requested from HCW?	<input type="checkbox"/> Yes	Date requested / /
Fingerprints received from HCW?	<input type="checkbox"/> Yes	Date received / /
Fingerprints submitted to Salem?	<input type="checkbox"/> Yes	Date submitted / /
Fingerprints returned from Salem?	<input type="checkbox"/> Yes	Date returned: / /
Initial criminal history fitness determination clearance?	<input type="checkbox"/> Yes	
SDS 0736 form, Enrollment form completed?	<input type="checkbox"/> Yes	
Orientation verified?	<input type="checkbox"/> Yes	
Live in orientation taken?	<input type="checkbox"/> Yes	
Abuse investigation noted on application?	<input type="checkbox"/> Yes	
Application status: <input type="checkbox"/> Approved <input type="checkbox"/> Closed <input type="checkbox"/> Denied <input type="checkbox"/> Voluntary withdrawal		

Provider number: _____

If denied at initial application, indicate date: ____ / ____ / ____

Reason for denial:

Approved to work in ORACCESS?

Yes