Seniors and People with Disabilities
Oregon Home Care Commission

Homecare Worker Application

Office Use Only		
Provider #:		
☐ Career	☐ Exclusive	☐ Restricted

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

1. Personal Information

Name: (Last/First/Middle Initial) (*As shown on your Social Security card.*)		Date of Birth: / /
Other names used, including maiden and nicknames:		Email address: (Optional)
Street Address:	**Mailing Address:** *(If different than Street Address)*	
Street	Street or PO Box	
City, State, Zip	City, State, Zip	
Your phone number(s) Home: ( )	Cell: ( )	Message: ( )

2. Specific Client – Employer – New Homecare Workers Only

Have you already agreed to work for a particular client-employer? ☐ Yes ☐ No
If yes, please include the name of the individual: ______________________
Are you willing to work for other client-employers? Now? ☐ Yes ☐ No In the future? ☐ Yes ☐ No

3. Orientation and Certified Training

Have you attended a Homecare Worker 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)

4. Transportation

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?	☐ Yes	☐ No
Drive an employer's car?	☐ Yes	☐ No
Escort an employer on public transportation?	☐ Yes	☐ No
Escort an employer in their car?	☐ Yes	☐ No

5. Language - In Order of Ability

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

1.	____________	☐ Speak	☐ Read	3.	____________	☐ Speak	☐ Read
2.	____________	☐ Speak	☐ Read	4.	____________	☐ Speak	☐ Read

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6. Availability to Work

Are you currently looking for work? ☐ Yes ☐ No

Check all work types you are willing to consider:

- ☐ Full-time (over 20 hours per week)
- ☐ Part-time (20 hours per week or less)
- ☐ Being a live-in (24 hour service)
- ☐ Providing live-in relief
- ☐ Providing substitute services paid by the hour
- ☐ Working with short notice

7. Work Schedule

Check the days/times you are available for work.

If you are available at all times check here ☐

Weekday	Mornings	Afternoons	Evenings	Nights
Monday	☐	☐	☐	☐
Tuesday	☐	☐	☐	☐
Wednesday	☐	☐	☐	☐
Thursday	☐	☐	☐	☐
Friday	☐	☐	☐	☐
Saturday	☐	☐	☐	☐
Sunday	☐	☐	☐	☐
Holidays	☐	☐	☐	☐

8. Services and Work Experience

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	☐	☐
Bathing	☐	☐
Dressing	☐	☐
Feeding	☐	☐
Grooming	☐	☐
Personal Hygiene	☐	☐
Positioning	☐	☐
Toileting	☐	☐
Transferring	☐	☐

Name: (Last/First/Middle Initial) (*As shown on your Social Security card.*)	Date of Birth: / /

8. Services and Work Experience Continued

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	☐	☐
Housekeeping	☐	☐
Laundry	☐	☐
Meal preparation	☐	☐
Shopping	☐	☐
Transportation	☐	☐

Health – Related Procedures	**Willing**	**Experience**
Bowel program	☐	☐
Feeding Tube	☐	☐
Home dialysis	☐	☐
Injections	☐	☐
Ostomy care (e.g., colostomy, ileostomy)	☐	☐
Range of motion or exercise	☐	☐
Suctioning	☐	☐
Tracheotomy care	☐	☐
Urinary catheter care	☐	☐
Wound care	☐	☐

9. Additional Information

Your gender: ☐ Female ☐ Male

Do you smoke? ☐ Yes ☐ No If you smoke, are you willing to smoke outside? ☐ Yes ☐ No

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

(Check all that apply)

☐ Activities of Daily Living (see page 2)	☐ Self-Management Tasks (see above)
☐ Alzheimer's or other dementias	☐ 65 years of age or older
☐ Behavioral disorders	☐ Smokers
☐ Females	☐ Terminally ill
☐ Males	☐ Under 65 years of age
☐ People with pets	☐ Using medical marijuana

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10. Geographical Location

Where are you willing to work? (*List as many as you wish.*)

Counties: ______________________________

____

Cities:/Areas within the Counties: ______________________________

____

11. Abuse Investigation

Have you ever been investigated for abuse, neglect or domestic violence? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

____

12. Applicant Certification

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).

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 and provider number) will be released to anyone seeking in-home services.

- I agree to have my contact information released through the RRS. ☐ Yes ☐ No
  I understand that checking "No" will limit the number of referrals I will receive.
- If yes, I agree to have my contact information referred to individuals who pay privately for in-home services.
  I understand the hours worked for individuals who pay privately for services DO NOT count toward Service Employees International Union (SEIU) Local 503, Oregon Public Employees Union (OPEU) negotiated benefits and may not have worker's compensation or unemployment insurance. ☐ Yes ☐ No

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: / /

Name: (Last/First/Middle Initial) (*As shown on your Social Security card.*)	Date of Birth: / /

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Branch office where application was submitted: ______________________

I-9 Form completed? ☐ Yes

Is Provider 18 years of age or older? ☐ Yes

W-4 Form completed? ☐ Yes

DHS 0301 Form completed and submitted to local office? ☐ Yes Date submitted / /

SDS 0356 signed and witnessed? ☐ Yes

If CPR Certified, expiration date verified? ☐ Yes Expiration date / /

If First Aid Certified, expiration date verified? ☐ Yes Expiration date / /

Fingerprints requested from HCW? ☐ Yes Date requested / /

Fingerprints received from HCW? ☐ Yes Date received / /

Fingerprints submitted to Salem? ☐ Yes Date submitted / /

Fingerprints returned from Salem? ☐ Yes Date returned: / /

Initial Criminal History Fitness Determination Clearance? ☐ Yes

SDS 0736 Form, Enrollment form completed? ☐ Yes

Orientation verified? ☐ Yes Date completed: / /

Abuse investigation noted on application? ☐ Yes

Application Status: ☐ Approved ☐ Closed ☐ Denied ☐ Voluntary withdrawal

Provider Number: ______________

If denied at initial application, indicate date: / /   Reason for denial: ______________________

Approved to work in OACCESS? ☐ Yes