

## Select originating cluster

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**Authorized Signature**

**Number:** SPD-IM-04-116  
**Issue Date:** 12/23/2004

**Topic:** Provider Information

**Subject:** New Homecare Worker Application forms: Career (DHS 0355) and Exclusive (DHS 0355B) and Training Resources

**Applies to (check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> All DHS employees                 | <input type="checkbox"/> County Mental Health Directors                  |
| <input checked="" type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services                                 |
| <input type="checkbox"/> Children, Adults and Families     | <input checked="" type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> County DD Program Managers        | <input type="checkbox"/> Other (please specify):                         |

**Message:** New Homecare Worker application forms are being piloted and are available for use on the DHS forms server. At this time, it is not mandatory that all SPD/AAA offices begin using these application forms. They are accessible for any office that may wish to begin using them. These application forms are a result of recommendations made by the Home Care Commission Registry committee. The intent is that eventually all SPD/AAA offices will begin using one standardized application form.

The application forms include the DHS 0355 Career Homecare Worker Application form and the DHS 0355B Exclusive Homecare Worker Application form. The Career HCW application form is for those Homecare Workers who wish to market their services to clients in general. The Exclusive HCW Application form is for Homecare Workers who have a limited enrollment to care for specific clients as described in OAR 411-031-0040(8) (d).

These new application forms do not replace the need for Homecare Workers to complete other necessary forms as part of the application packet. The other mandatory forms which must be completed include:

- DHS 0301 Criminal History Check Authorization form
- U.S. Bureau of Citizenship and Immigration form I-9 (see IM 04-048 for details)
- SDSD 0736 In-Home Services Provider Enrollment form

The Home Care Commission Training committee has started a web page for training resources for Homecare Workers. The only mandatory instruction at this time is participation in a Homecare Worker orientation through the local office but some Homecare Workers may be interested in gaining more skills. Training opportunities and on-line information have been compiled by the University of Oregon Labor Education Research Center (LERC) in cooperation with SEIU Local 503, OPEU, the Home Care Commission, DHS and SAIF. A link to this "Training Resources" web page has been placed on the DHS-SPD Homecare Workers webpage located at: <http://www.dhs.state.or.us/spd/tools/homecare/index.htm>

*If you have any questions about this information, contact:*

<b>Contact(s):</b>	Mary L. Lang, In-Home Services Program Coordinator		
<b>Phone:</b>	(503)945-5799	<b>Fax:</b>	(503)947-4245
<b>E-mail:</b>	Mary.l.lang@state.or.us		



# Exclusive Homecare Worker Application Form

An Exclusive Home Care Worker (HCW) is someone who intends to serve a family member, neighbor or friend - - and is not interested and will not be referred to other potential clients.

**Instructions: Please use a pen to fill out the application. Make sure you sign and date the last page.**

## 1. Exclusive Homecare Worker Information

Name of person you have already agreed to work for: \_\_\_\_\_

Relationship to the person you are working for: \_\_\_\_\_  
(Such as friend, mother, brother, sister, parent, etc.)

Do you have a provider number issued by the Department of Human Services (DHS)?

Yes  
 No  
 Unsure

If **yes**, please include number here if known: \_\_\_\_\_

## 2. Personal Information

Last name (as shown on Social Security Card)	First name	Middle initial
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Other names used, including maiden names and nick-names

Print your name as you would like it to appear on the registry

Male  Female

Gender

Date of Birth

Email Address (optional)

**Street Address**

**Mailing Address**, if different than street address

Street or PO Box

Street or PO Box

City, State and Zip Code

City, State and Zip Code

County

County

Your telephone number, include area code: (     )     -

Is this your Home Telephone, Cell Phone or Other? Please circle.

Alternate telephone number (optional): (     )     -

Check here if you **do not** have a phone number:

3. Abuse Investigation	
Has there been an abuse investigation on you that has been substantiated?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
If Yes, please explain:	

4. Applicant Certification
<p>I certify that all information I supplied in this application is accurate to the best of my knowledge. I understand that purposeful misrepresentation may result in rejection of my application. I also understand that it is my responsibility to keep such information current and accurate by updating it as often as necessary.</p>

Applicant signature	Date
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For Office Use Only	
Branch office where application was submitted:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	I-9 form completed?
<input type="checkbox"/> Yes <input type="checkbox"/> No	DHS 0301 form successfully completed? Date submitted:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Determined "fit" for limited enrollment?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Provider enrollment form completed?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cleared to work as an Exclusive HCW?
<b>Provider number:</b>	
Provider number status: <input type="checkbox"/> Active <input type="checkbox"/> Terminated <input type="checkbox"/> Suspended <input type="checkbox"/> Inactive <input type="checkbox"/> Denied	
If denied at initial application, date:	Reason:



# Career Homecare Worker Application Form

Seniors and People with Disabilities

A Career Homecare Worker (HCW) is someone who wants to provide care for a number of clients or to receive referrals to potential clients

**Instructions: Please use a pen to fill out the application. Make sure you sign and date the last page.**

## 1. Career Homecare Worker Information

Have you already agreed to work for a particular client?  Yes  No

If **yes**, please include their name: \_\_\_\_\_

Do you have a provider number issued by the Department of Human Services?  Yes  No  
 Unsure

If **yes**, please include number here if known: \_\_\_\_\_

## 2. Personal Information

Last name (as it appears on your Social Security Card)      First name      Middle Initial

Other names used, including maiden names and nick-names

Print your name as you would like it to appear on the registry

Male  Female

Gender

Date of Birth

Email Address (optional)

Street Address:

Mailing Address: if different than street address

Street or PO Box

Street or PO Box

City, State and Zip Code

City, State and Zip Cod

County

County

Your telephone number, including area code: (    )    -

Is this your Home Phone, Cell Phone or Other? (Please Circle)

Alternate telephone number: (optional) (    )    -

Check here if you **do not** have a phone number:

What kind of transportation do you use?  Car  Bus  Other (specify): \_\_\_\_\_

Driver's license number: \_\_\_\_\_ State issuing license: \_\_\_\_\_

Oregon ID number: \_\_\_\_\_

What language do you normally speak? \_\_\_\_\_

What other languages do you speak? (Include sign language.) \_\_\_\_\_

Do you smoke? Yes  No  Comments: \_\_\_\_\_

**3. Referral Information (Select as many as desired.)**

Are you interested in:

Full-time Work?  Being a Live-In HCW?

Part-time Work?  Substitute or Short Notice Work?

Other type of home care work? Specify: \_\_\_\_\_

**In what geographic locations are you willing to work? (List as many as you wish.)**

Counties: \_\_\_\_\_

Cities: \_\_\_\_\_

If you specify **Portland** as a geographic area in which you are willing to work, please select one or more of the city areas listed:  Southeast  North  Northeast  West

**4. Availability for Work**

Are you currently available and seeking work? Yes  No

If **yes**, complete the next two items. If **no**, skip to Work Experience, Section 6.

Please check the days of the week you are available for work:

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

Please check the time of day you are generally available for work:

Mornings  Afternoons  Evenings  Nights  Holidays

**5. Preferences**

Please indicate the type of clients that you are willing to work with. (Check all that apply.)

Male clients  Terminally ill clients  Clients with physical disabilities

Female clients  Clients who use medical marijuana  Clients who smoke cigarettes

Clients with behavioral problems or thought disorders like mental illness or Alzheimer's Disease

## 6. Work Experience

Please check each task you have experience with or are willing to do

**Homemaking tasks:**     Meal preparation                       Housekeeping     Transportation  
 Giving or setting up medications     Shopping                       Laundry

**Care services:**     Feeding             Dressing             Toileting             Personal hygiene  
 Grooming             Bathing             Mobility             Transferring, positioning

Use of assistive devices or other equipment, (e.g., Hoyer lift)  
 Working with behaviors that require a skillful response

**Other health-related medical procedures:**     Injections                       Wound care  
 Ostomy care (e.g., colostomy, ileostomy)     Bowel program                       Home dialysis  
 Tracheotomy care                       Suctioning                       Catheter care

## 7. Documented Training

Please specify training that you have completed and for which you can provide documentation

Training: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Training: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Training: \_\_\_\_\_ Expiration date: \_\_\_\_\_

## 8. Worker Limitations

If you have work limitations, please describe them below

Lifting limitations:     Yes  No    Specify: \_\_\_\_\_

Health, physical limitations:     Yes  No    Specify: \_\_\_\_\_

Hearing or speech limitations:     Yes  No    Specify: \_\_\_\_\_

Other limitations:     Yes  No    Specify: \_\_\_\_\_

## 9. Abuse Investigation

Has there been an abuse investigation on you that has been substantiated?

Yes  
 No  
 Unsure

If yes, please explain:

## 10. Applicant Certification

I certify that all information I supplied in this application is accurate to the best of my knowledge. I understand that purposeful misrepresentation may result in rejection of my application or denial of placement on the registry.

**I also understand that if I am applying to be a Career Homecare Worker, that selected information in this application may be released to the public to assist clients in the selection of a Homecare Worker and I approve such releases. Furthermore, I understand that it is my responsibility to keep such information current and accurate by updating it as often as necessary.**

**Applicant signature**

**Date**

### For Office Use Only

Branch office where application was submitted:

Yes  No

I-9 form completed?

Yes  No

Provider 18 years of age or older?

Yes  No

DHS 0301 completed and submitted to local office? Date submitted:

Yes  No

Criminal History Fitness Determination Clearance?

Yes  No

Provider enrollment form completed?

Yes  No

Provider Orientation completed? If yes, date:

Yes  No

Cleared to work?

**Provider number:**

Provider number status:  Active  Terminated  Suspended  Inactive  Denied

If denied at initial application, date:

Reason: