

San Bernardino County In-Home Supportive Services Public Authority

784 E. Hospitality Lane San Bernardino, CA 92415-0034

• Toll Free 1 (866) 985-6322 • Fax (909) 891-9130

CLIENT REGISTRY ASSESSMENT



NAME: _____
Last Name First Name MI

ADDRESS: _____, CA _____
Street City Zip Code

SS#: _____ - _____ - _____ **PHONE:** (____) _____ **E-mail** _____

IHSS SOCIAL WORKER'S NAME: _____ **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 Yes No Preference / under what condition:
is a smoker? _____
5. Do you have pets in your home? Yes No
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