



Michigan Department of Health and Human Services  
**Provider Application for Registry**

**INSTRUCTIONS**

Please fill out the application as completely and as neatly as possible. Be sure to sign and date your completed application. Completed applications should be mailed to:

**Home Help Registry  
PO Box 1482  
Okemos, MI 48805**

If you have any questions about the application or the provider registry, please call the registry hotline at **1-800-979-4662**.

Personal Information - Print your full name (last, first, middle), date of birth, address and other information as available.

Other Relevant Information - Fill in all areas that apply to you.

Training and Certification - If you have completed the trainings listed in this section check "Yes" or "No" for any of the listed trainings. If YES, provide the expiration date of the certification if you know your completion date.

Languages Spoken - Check the languages that you feel comfortable speaking on the job. If a language is not listed, then add it under "Other."

Driving and Access to a Car - You only need to fill in the section if you are both able and willing to drive either your car or your employer's car while on the job.

Work History - Provide information about your most recent work history if any.

Personal References - Provide contact information for at least two people who know you well. Do not list family members.

Work Preferences – This section is used to determine the types of work you are willing and able to do and the variety of people you wish to work with to provide services. Check all that apply. If you have experience working with certain types of people or in doing any of the listed tasks, check the "Experienced" box.

Schedule Preferences - This section is used to help match the work hours you want with the needs of potential clients. Be as accurate and as complete as possible. If you do not provide available times it could result in a lack of referrals. But not providing available times that you are able to work may prevent you from receiving referrals.

Criminal Background Check – Provide information on any criminal convictions. Please note that a "Yes" answer, even a felony conviction, does not necessarily make you ineligible to be placed on the registry.

**Be sure to sign and date your application.**

AUTHORITY: P.A. 280 of 1939, as amended.  
COMPLETION: Required.  
PENALTY: Application may not be approved.

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Name \_\_\_\_\_ / /  
Last First MI Date of Birth (MM/DD/YYYY)

Residence Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_  
*(Street or P.O. Box)*

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_  
*(If different from above)*

County of Residence: \_\_\_\_\_ Gender:  Male  Female  
*Gender will be used only when a consumer requests a provider of the same gender to provide personal care.*

Home Phone: ( ) \_\_\_\_\_ Emergency Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Email Address: \_\_\_\_\_

**OTHER RELEVANT INFORMATION**

Are you currently providing Home Help through the Michigan Department of Health and Human Services (MDDHS)?  
 Yes  No  
**If yes, for whom?**  Relative  Non-Relative

Do you require any accommodation?  Yes  No If yes, please describe:  
\_\_\_\_\_

Do you smoke?  Yes  No If yes, will you smoke only outside at work?  Yes  No

Will you work for consumers who smoke?  Yes  No

Would you be willing to work in a home with:  
Cats?  Yes  No Dogs?  Yes  No Other \_\_\_\_\_ No

Could you work for someone with fragrance sensitivities?  Yes  No

Please list any allergies or sensitivities that would prevent you from working in someone's home:  
\_\_\_\_\_

**TRAINING AND CERTIFICATION**

*Please check if you have had recent training in this area and can provide proof of training, such as certificates.*

Certified Training	Completed Training	Expiration Date
First Aid	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
CPR (cardiopulmonary resuscitation)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
CNA (certified nursing assistant)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
CMH (Community Mental Health)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Other Home Help/Home Care relevant training, skills or experience? Please list:  
\_\_\_\_\_

Are there any skills for which you would like to see training offered? Please list:  
\_\_\_\_\_

**LANGUAGES SPOKEN** *Check all the languages you speak well enough to provide care.*

American Sign  Arabic  English  Hmong  
 Spanish  Vietnamese Other \_\_\_\_\_

What one language do you speak best (including English)? \_\_\_\_\_

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**DRIVING AND ACCESS TO A CAR** (Check Yes or No. A car isn't necessary for many jobs.)

Are you willing to use your car on the job?  Yes  No Yes, provide Drivers License and Insurance Company.  
 Are you willing to drive a consumer's car?  Yes  No Yes, provide Drivers License and Insurance Company.

Valid Drivers License Number and State: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

What counties are you willing to work in? \_\_\_\_\_

How many miles are you willing to drive or travel for work one way? \_\_\_\_\_

**WORK HISTORY**

*Please list any HOME HELP/HOME CARE job(s) that you have had lasting 30 days or more in the last five years that we may call as references. Begin with your most recent work. If you do not have HOME HELP/HOME CARE work references, list any other work. We must reach three references, preferably for current or previous employment, volunteer work, or from a school you have recently attended. If you do not have three work or school references, provide us two personal references.*

Employer or Consumer:	Phone #
Address:	Best times to call:
Your Job Title:	Permission to call: <input type="checkbox"/> Yes <input type="checkbox"/> No
Supervisor's/Consumer's Name (if different from above)	Period of employment:
	From (month/yr) _____ to(month/yr) _____
Reason for leaving:	
<b>For Office Use Only:</b> <input type="checkbox"/> Positive HH/HC reference <input type="checkbox"/> Other positive work reference <input type="checkbox"/> Unable to contact Verify? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer or Consumer:	Phone #
Address:	Best times to call:
Your Job Title:	Permission to call: <input type="checkbox"/> Yes <input type="checkbox"/> No
Supervisor's/Consumer's Name (if different from above)	Period of employment:
	From (month/yr) _____ to(month/yr) _____
Reason for leaving:	
<b>For Office Use Only:</b> <input type="checkbox"/> Positive HH/HC reference <input type="checkbox"/> Other positive work reference <input type="checkbox"/> Unable to contact Verify? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer or Consumer:	Phone #
Address:	Best times to call:
Your Job Title:	Permission to call: <input type="checkbox"/> Yes <input type="checkbox"/> No
Supervisor's/Consumer's Name (if different from above)	Period of employment:
	From (month/yr) _____ to(month/yr) _____
Reason for leaving:	
<b>For Office Use Only:</b> <input type="checkbox"/> Positive HH/HC reference <input type="checkbox"/> Other positive work reference <input type="checkbox"/> Unable to contact Verify? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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**PERSONAL REFERENCES**

List two people you know personally whom we can contact as references. Do not list family members.

Name:	Home phone #:
How do you know this person and for how long?	Work phone #:
Office: Check if positive reference <input type="checkbox"/>	

Name:	Home phone #:
How do you know this person and for how long?	Work phone #:
Office: Check if positive reference <input type="checkbox"/>	

**WORK PREFERENCES**

Please check boxes indicating if you are experienced in or willing to assist in any of the following areas. We cannot guarantee consumers calling you will match all your preferences. We encourage you to consider performing all tasks and serving all consumers.

Work with persons who are:	Yes	Maybe	No	Experienced	Personal care including:	Yes	Maybe	Yes	Experienced
Men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Helping with medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting/transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adults (18 - 62)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elderly (65 plus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Terminally ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmentally Disabled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mentally ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toileting, diapers, bed pans, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toileting, catheters/ colostomy bags	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Vision impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Multiply impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

  

Domestic tasks including:	Yes	Maybe	No	Experienced
Meal Preparation & clean-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping/errands (no car required)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SCHEDULE PREFERENCES**

Are you willing to work:  Routine Care     Holidays     Backup Care     Emergency on-call

Check all the days and times you are available to work weekly:

<input type="checkbox"/> All Mornings (6-12)	<input type="checkbox"/> Mon	<input type="checkbox"/> Tue	<input type="checkbox"/> Wed	<input type="checkbox"/> Thu	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat	<input type="checkbox"/> Sun
<input type="checkbox"/> All Afternoons 12-6)	<input type="checkbox"/> Mon	<input type="checkbox"/> Tue	<input type="checkbox"/> Wed	<input type="checkbox"/> Thu	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat	<input type="checkbox"/> Sun
<input type="checkbox"/> All Evenings (6-12)	<input type="checkbox"/> Mon	<input type="checkbox"/> Tue	<input type="checkbox"/> Wed	<input type="checkbox"/> Thu	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat	<input type="checkbox"/> Sun
<input type="checkbox"/> All Midnights (12-6)	<input type="checkbox"/> Mon	<input type="checkbox"/> Tue	<input type="checkbox"/> Wed	<input type="checkbox"/> Thu	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat	<input type="checkbox"/> Sun

*Most consumers need part-time providers. You can accept more than one part-time job if you prefer a full-time schedule.*

What are the FEWEST hours per week you would be willing to work for one individual consumer?

0-5 hours per week     6-10 hours per week     11-25 hours per week     26+ hours per week

What is the GREATEST number of hours you would be willing to work for an individual consumer?

0-5 hours per week     6-10 hours per week     11-25 hours per week     26+ hours per week

Please check whether you want short-term or long-term jobs.

No Preference     Short-term (Less than 3 months)     Long-term (More than 3 months)

Are you willing to work for more than one consumer?  Yes     No

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**CRIMINAL BACKGROUND CHECK**

Have you been convicted of a felony?  Yes  No (A "yes" answer does not automatically disqualify you from being on the Registry. If yes, list the type of felony for all convictions, the date of conviction, as well as the State and County: Use additional paper if more space is needed..)

Felony: \_\_\_\_\_ Sentence: \_\_\_\_\_ Conviction Date: \_\_\_\_\_

Date of Sentence Completion \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_

Name and phone numbers of your parole/probation officers we can contact as references:

Have you been convicted of a misdemeanor?  Yes  No

Misdemeanor: \_\_\_\_\_ Sentence: \_\_\_\_\_ Conviction Date: \_\_\_\_\_

Date of Sentence Completion \_\_\_\_\_ State: \_\_\_\_\_ County: \_\_\_\_\_

I certify that I am at least 18 years of age and all information on this form is true to the best of my knowledge. I understand that any omission or misrepresentation of information on this form may disqualify me from being listed on the registry. I give the MDHHS or its designee permission to conduct a criminal background check. I will report any changes in my criminal history status that occur after this date. I give the MDHHS or its designee permission to share my criminal history and other relevant information in my file with individual consumers who are looking for providers.

I understand that I am filling out this application:

- to possibly list my name on the registry but the application is no guarantee of employment;
- that a consumer must agree to select me for employment; and
- that the MDHHS is not responsible in any way for finding employment for me with a consumer.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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