Independent Contractor Registration Form

PERSONAL INFORMATION				
First Name	Middle Name	Last Name		
Street Address	Apt. #	City	State	Zip Code
Home Phone Number	Cell Phone Number	Date of Birth MM/DD/YYYY		
Driver's License State / Number	Social Security Number			
Email Address	Registration ID Number (EIN)			

EDUCATION	
Please provide the name and city/state of each institution.	
High School:	Graduated ☐Yes ☐No ☐ GED
College:	Graduated ☐Yes ☐No Major:
Professional School:	Graduated ☐Yes ☐No

WORK HISTORY		
Please list your three most recent contracts or work assignments, starting with your current or last.		
1	Name:	Position:
Start Date: _____ End Date:_____ Last Date Worked: _____ ☐Still working		
*Reason for leaving:		
Person to contact for reference:		Contact Phone:
2	Name:	Position:
Start Date: _____ End Date:_____ Last Date Worked: _____ ☐Still working		
*Reason for leaving:		

Person to contact for reference:		Contact Phone:
3	Name:	Position:
Start Date: _____ End Date:_____ Last Date Worked: _____ ☐ Still working		
*Reason for leaving:		
Person to contact for reference:		Contact Phone:

Professional Credentials

_____

License/ Certification Type | License/ Certification No. | State | Expiration Date

_____

License/ Certification Type | License/ Certification No. | State | Expiration Date

Information concerning renewal of the applicable license, registration, or certification (specify):

_____

I currently am registered as a contract caregiver with the following companies:

1	Name:	Contact Phone:
2	Name:	Contact Phone:
3	Name:	Contact Phone:
4	Name:	Contact Phone:

Authorization and Release

My signature below attests to the truthfulness of the information I have provided.

I am registering as an Independent Contractor with Just Like Family Home Care, LLC and hereby authorize Just Like Family Home Care, LLC to contact the work references listed above regarding my work performance. Further, I hereby authorize and give permission to the work references listed above to release to Just Like Family Home Care, LLC all information regarding my work performance. In addition, I hereby release the work references listed above from any and all liability which may result from the release of such information.

_____ _____

Contractor Name (Please Print) Witness

_____ _____

Contractor Signature Date

CAREGIVER RATE SHEET

Contractor Name_____ Date_____

RN ☐ LPN ☐ CNA ☐ HHA ☐ Companion/ Homemaker/Sitter ☐

As a caregiver registering as an Independent Contractor on the referral list for Just Like Family Home Care, LLC, I understand that I am self-employed and negotiate the rates I receive for the clients I am referred to. I also understand that, in addition to the rate I agree upon with the client, Just Like Family Home Care will charge the client a referral fee. I realize that, if I set my rates too high, other caregivers may be more affordable to the clients and thereby have more opportunities for referrals.

I am interested in the following referrals: Hourly ☐ Live-In/ Daily ☐

Just Like Family Home Care, in its marketing and administrative functions, attempts to identify client opportunities within a caregiver's preferred range of rates.

Caregiver's Rates:

Preferred Hourly Rate

$_____/ Hour

Low-End Hourly Rate I am willing to accept

$_____/ Hour

Preferred Live-In/ Daily Rate

$_____/ Hour

Low-End Live-In/ Daily Rate I am willing to accept

$_____/ Hour

_____ _____

Contractor Printed Name Date

_____

Contractor Signature

Independent Contractor Availability and Experience

Contractor Name:

Please indicate your availability by checking the boxes below:

HOURLY

☐ MORNINGS ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN

☐ AFTERNOONS ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN

☐ NIGHTS ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN

LIVE-IN ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN

GENERAL INFORMATION

Please answer the following questions by checking the yes or no boxes below.

	YES	NO		YES	NO
Will you use your car to transport clients?	☐	☐	Will you accept referrals for male clients?	☐	☐
Will you drive the client's car?	☐	☐	Will you accept referrals for female clients?	☐	☐
Will you accept referrals for clients with pets?	☐	☐	Do you smoke?	☐	☐
If yes, please specify below:			Will you accept referrals for clients who smoke?	☐	☐
All types of dogs	☐	☐			
Small dogs	☐	☐			
Cats	☐	☐			
Will you accept referrals to care for pets?	☐	☐			

Please list any other restrictions or allergies:

Please check to indicate any training or experience you have in the following areas:

	Care Experience		Diagnosis		Housekeeping
☐	Amputees	☐	Alzheimer's	☐	Cooking - American
☐	Bed Bound Status	☐	Cancer	☐	Cooking - Special Diet
☐	Catheter	☐	CHF	☐	Puree/ Thicken Food
☐	Prosthetic Arms/Legs	☐	COPD Emphysema	☐	Errands/ Grocery Shopping
☐	Dialysis	☐	Dementia	☐	Ironing
☐	IVs	☐	Diabetes	☐	Laundry
☐	New Caregiver	☐	MRSA	☐	Light Housekeeping
☐	Oxygen	☐	Parkinson's	☐	Pet Care
☐	Paralyzed	☐	Seizures	☐	Transportation
☐	Pediatrics	☐	Shingles		
☐	Pressure Stockings	☐	Stroke		
☐	Colostomy Bag	☐	Alcoholism		
☐	Tube Feeding	☐	Drug Addiction		
☐	Wheelchair	☐	Heart Attack		

	Personal Care		Mental Health		Hospice
☐	Female Care	☐	Combative/ Agitated Behavior	☐	End of Life Care
☐	Male Care	☐	Depression	☐	Current TB
☐	Incontinent	☐	Mental Illness		
☐	Diapering				

	Training *certificates needed*		Lifting		Post Operative
☐	HHA 40	☐	Heavy Lifting	☐	Cosmetic Surgery
☐	HHA 75	☐	Hoyer Lift	☐	Hip Replacement
☐	Alzheimer's 2hr	☐	Gait Belt	☐	Knee Replacement
☐	Alzheimer's 4 hr	☐	Lifting/ Transferring	☐	Mastectomy
☐	HIV/ AIDS course				
☐	First Aid				

Please check to indicate any training or experience you have in the following areas:

	Disabilities		**Disability Training** *certificates needed*		**Fluent Language Ability**
☐	Pediatric	☐	Medication Administration 4 hr.	☐	English
☐	Young Adults	☐	Local Background Check	☐	Spanish
☐	Adults	☐	Intro to Development Disabilities Class	☐	Creole
☐	Cognitive Delay	☐	Health & Safety Disabilities Class	☐	French
☐	Social-Emotional Delay	☐	Zero Tolerance Disability Class	☐	German
☐	Communication Delay	☐	Medicaid Waiver Service Agmt. Class	☐	Sign Language
☐	Sensory Impairment	☐	Person-Centered Approach Class	☐	Other
☐	Autism	☐	Choices & Rights		
☐	Cerebral Palsy	☐	Medicaid Waiver Documentation		

Please list any additional training or experience that is not listed above: