



Public Authority

In-home Supportive Services

Registry Provider Update Form:

1. PLEASE COMPLETE THE UPDATE FORM BY FILLING IN ALL SECTIONS.

Please print clearly if form is not completed on-line:

First Name: *
Middle Initial: *
Last Name: *

Home Address: * Check box for new address
 City: *
Zip Code: *

Cell # * Check box if this is a new #
 Message or Home:
Provider Email: *

(Clients will be calling this #)

Mailing/P.O Box Address: *
Last 4 digits of Social Security #: *

2. PLEASE PROVIDE THE NAME OF YOUR CLIENT/CLIENTS THAT YOU ARE CURRENTLY WORKING FOR AT THIS TIME. IF YOU DO NOT HAVE A CLIENT PLEASE TYPE OR PRINT N/A.

Client 1: *
Client 2: *
Client 3: *

3. AVAILABILITY FOR THE REGISTRY: PLEASE CHECK✓BOXES THAT REFLECT YOUR CURRENT AVAILABILITY TO BE REFERRED OUT.

I currently have enough clients at this time. I will now only be required to update every 3 months, as I am "Fully Employed" and DO NOT need to be referred out.

I am no longer interested in working; please remove my name from the registry.

Other: Personal/Medical explanation in box:

4. PLEASE ENTER YOUR AVAILABILITY BELOW: ONLY ENTER TIMES YOU ARE AVAILABLE TO WORK FOR NEW CLIENTS.

EXAMPLE: BELOW

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
9 AM-4 PM		9 AM-4 PM		9 AM- 4PM		9 AM 4-PM

PLEASE ADD YOUR AVAILABILTY BELOW:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

FOR ANY OTHER CHANGES PLEASE CALL THE PUBLIC AUTHORITY AT: 1-866-985-6322 OPTION #3

IN-PERSON: PROVIDERS SIGNATURE: _____ DATE: _____