

Provider Questionnaire

We will be compiling a resource list of available providers and would like to know if you would be interested in having your name and information included. This list will be made available to clients and their families and other individuals inquiring about possible resources in respite care.

Please complete and fax/mail this questionnaire to:

Polk County Developmental Disabilities Program
Attn: *Family Support Coordinator*
182 SW Academy ST. Dallas, OR 97338

FAX: 503-623-1874

*Signing this document indicates your permission for PCDDP to provide your name to families interested in your services.

NAME: _____

PHONE: _____ **E-MAIL:** _____
Best time to call: _____

Please check all that apply:

Type of care provided:

Respite Other _____
(e.g. bathing, feeding, in home support, etc.)

Days & Hours willing to work:

Sun Mon Tue Wed Thur Fri Sat

Any Shift Day Shift Swing Shift Graveyard Shift

Full Time Part Time Live-in

Are you comfortable working with children who have increased medical needs?

Yes No

Do you prefer working from home or at client's residence?

Your home Client's Home Community Activities

What age groups are you able to provide for?

Infants Toddlers Grade School Junior High High School
 Adults Seniors

Do you speak any languages other than English?

What types of disabilities are you prepared to care for?

What geographic area you are able to work in?

Do you have any other special qualifications/training that we should be aware of? (Skills Training, Behavior, Medically Fragile)

Do you have a current Oregon Driver's License? Yes No

Do you have reliable transportation? Yes No

Are you willing to work in a household with pets? Yes No

Are you willing to work in a household of a smoker? Yes No

Desired Rate of Pay:

*Please be aware that family supports current new provider rate is \$8.05/hr. This rate may change as of 7/1/2009 with the adoption of new family support rules.