

## COMMUNITY CARE FOSTER FAMILY HOME DISCLOSURE FORM

Please answer all of the following questions honestly. When form is complete return it to Community Ties of America, Inc. Any questions please call Community Ties of America, Inc. at (808) 234-5380 or (877) 236-5380.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Do you speak, read and write proficiently in English? YES or NO (**circle one**)

Are you a: Primary Caregiver or Substitute Caregiver (**circle one**) Are you a: NA CNA LPN RN (**circle one**)

**If PCG is completing this form:**

PCG completes entire form and signs the 2<sup>nd</sup> page.

**If SCG is completing this form:**

SCG completes Section 1 and signs 2<sup>nd</sup> page.

**SECTION 1: PCG's and SCG's must answer all of the questions in the box**

	YES	NO
Do you have any physical, mental disability or health related problem that would prevent or limit you from meeting the daily needs of clients 24 hours a day 7 days a week such as BUT NOT LIMITED TO: limitations in lifting, bad back, poor hearing, fragile diabetic, poor eyesight?		
Are you currently under the treatment of a physician or counselor? If yes, what kind of treatment.		
Do you take any medication that might affect your ability to respond to clients 24 hours a day, 7 days a week?		
Do you become angry or frustrated quickly with people who do not do what you want?		

**SECTION 2: The following questions are only for the Primary Caregiver to complete:**

1. How many people live in your house? \_\_\_\_\_ How many are children under the age of 18? \_\_\_\_\_  
 How many are above the age of 70? \_\_\_\_\_ How many household members are disabled? \_\_\_\_\_

2. Specify the ages of any children under 18? \_\_\_\_\_

3. Are any household members currently under the treatment of a physician or counselor?  
 Yes or No (**circle one**)

4. Does any household member take any medications that might affect the household routine if one or two doses are missed?  
 Yes or No (**circle one**)

5. Does any household member become angry or frustrated quickly with people who do not do what they want?  
 Yes or No (**circle one**)

6. Are you a 3 client certified CCFH? \_\_\_\_\_ If yes, date approved: \_\_\_\_\_

7. If you are applying for a 3 client certified CCFH who is your substitute CNA if you are out of CCFH over 5 hours a day/28 hours a week? (**IF YOU ARE NOT APPLYING for 3 client certified CCFH, Enter Not Applicable**)

\_\_\_\_\_

8. List all of your SCGs who are CNAs: \_\_\_\_\_

9. List all of your SCGs who are NAs: \_\_\_\_\_

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**SECTION 2 (Continued): The following questions are only for the Primary Caregiver to complete:**

10. Do you have any other jobs? If yes, how many hours do you work per day? (Use this area to explain any areas answered yes above, attach additional sheets if necessary:

**EXAMPLE: MONDAY: 12:00pm – 5:00pm, Tuesday: 9:00-Noon, Wednesday: No Work, Thursday: 1:00-4:00**

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**Explain any areas in which you answered No:**

1. In the 12 months has your household? (**check one**)

- A) (i) Paid all of your bills on time: Yes\_\_\_\_\_ No\_\_\_\_\_
- (ii) Had a telephone that is always available in the home Yes\_\_\_\_\_ No\_\_\_\_\_
- B) Will you have a fax available 24/7 if you become a CCFFH? Yes\_\_\_\_\_ No\_\_\_\_\_

2. Are you aware and open to other cultural beliefs Yes\_\_\_\_\_ No\_\_\_\_\_

3. Do all of your household members speak, read and write in English? Yes\_\_\_\_\_ No\_\_\_\_\_

If not, specify language used: \_\_\_\_\_

**Use this area to explain any areas answered No above, attach additional sheets if necessary:**

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**By signing below, I acknowledge that I have answered all questions honestly and to the best of my ability. I understand that by not completing this form entirely and/or falsifying information can lead to denial of an application or revocation of a certificate at a future date.**

I understand that the department or designee may request a medical or mental health clearance from my doctor if there are any concerns that are present now or in the future.

I also understand that client's in the Community Care Foster Family home are to be integrated into the daily life activities in the home to the greatest extent possible and that I shall provide for social and recreational activities of the client based on their service plan.

\_\_\_\_\_  
Print Name Primary Caregiver or Substitute Caregiver  
(circle one)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**All SCGs must provide a copy of this to every PCG they work for as part of their personnel record.  
Neither CTA nor the Department will supply a copy.**