

Community Ties of Amercia, Inc.

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Initial Substitute Caregiver Approval Request Form

Primary Caregivers are responsible to have an adequate number of substitutes for their home in order to provide for 24 hours a day/7 days a week of care of clients 365 days a year.

All substitutes must be trained on every client's service plan in the home by the client's Case Management Agency BEFORE they can be left alone with clients. Primary Caregivers are responsible for notifying CTA of all substitute caregiver changes in their home; this includes removing SCG's and adding SCG's using the "SCG Change Notification Form".

CTA has 30 days from the date of receiving an entirely completed package to process this request. All information must be completely filled out or if applicable, and attached to the form. The form will be returned to you without being processed if it is incomplete.

This form is to be used for Substitute Caregivers who have NEVER before been approved by CTA

Primary Caregiver's Name: _____ Phone: _____

Physical Address: _____

Current Case Management Agency(s) in the home _____

How many clients are you certified for: _____

Is this SCG a NA, CNA, LPN or RN? _____

Substitute Caregivers Name: _____ DOB: _____ Age: _____

A copy of the following must be attached to this request:

- Current government issued photo identification
- Copy of the substitutes current NA certificate, CNA card, LPN or RN license
- Current Tuberculosis Clearance
- Current Bloodborne Pathogen/Infection Control training, CPR and First Aid
- Current Background Checks
 - State and Federal fingerprinting results (every year for the first 2 years) – unless fingerprinting was done prior to 11-08 then only one is needed.
 - Hawaii State name check every other year starting in year 4 (2 years after the last fingerprinting results)
 - APS results (every year for the first 2 years and then every other year)
- Copy of Alternate Transportation (Non-Medical) Plan if the substitute cannot drive the client for non medical transportation **or** a copy of their Auto Insurance.
- Disclosure Form
- Job Experience Form *(if the PCG is a 3 Bed Certified Home)*

By signing this form I understand I am completely responsible to ensure that all requirements are maintained and up to date for this substitute caregiver. I understand that if any item expires that my home may be closed for non compliance with rules and regulations. I am responsible to keep all records for the substitute in my home and ensure that substitutes meet all yearly training requirements as listed in HAR 17-1454 regulations. I also understand that a client's case management agency may refuse to sign off on a SCG's training if, in their professional judgment, the SCG lacks the necessary skills to take care of the clients in my home.

Primary Caregiver signature: _____ Date: _____

By signing this approval form, I am accepting responsibility to follow all DHS requirements per HAR 17-1454 regulations. I understand that I must be trained by each client's case management agency on each client's service plan, complete a basic skills check and must receive nurse delegation before I can be left alone with any client.

Substitute Caregiver signature: _____ Date: _____