

Community Ties of Amercia, Inc.

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Substitute Caregiver Change Notification 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.

Primary Caregivers are responsible for notifying CTA of all substitute caregiver changes in their home, this includes removing SCG's and adding SCG's. This form serves to notify CTA of SCG changes in a home. CTA does not need to approve changes but must be notified per HAR 17-1454 regulations.

Primary Caregiver's Name: _____ Phone: _____

Physical Address: _____

How many beds is the PCG certified for: _____

Current Case Management Agency (s) in the home _____

Substitute Caregivers Name: _____ DOB: _____ Age: _____

Is this SCG a (*circle one*): NA CNA LPN RN

Are you removing this caregiver or adding this caregiver (*circle one*): ADDING REMOVING

If you are adding this caregiver what is date the SCG was approved by CTA: _____

Please list the First and Last name(s) of other Primary Caregivers that this substitute currently works for:

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: _____

YOU MUST ALSO SUBMIT THE ALTERNATE (NON-MEDICAL) TRANSPORTATION PLAN ONLY IF the SCG is a driver

If requesting to add a SCG who was already approved by CTA, please have the SCG read and sign this statement:

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.

SCG's signature _____ Date: _____