COMMUNITY CARE FOSTER FAMILY HOME
SUBSTITUTE CAREGIVER DISCLOSURE FORM
Do Not Send This Form to CTA – Keep only in home record

Name: _____ DOB: _____ Age: _____

SCG Home Address: _____

SCG Phone: _____ SCG Email address: _____

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

If not, in what language do you communicate _____ Are you a: <3 hr NA CNA LPN RN (***circle one***)

Are you aware of and open to other cultures and beliefs? YES or NO (***circle one***)

	YES	**NO**
Do you have any physical, mental 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 including but not limited to transfers and lifting (For example: Diabetes, heart or vascular disease, hearing or vision impairment, depression, fatigue, anxiety, muscle strain, back or joint problems)		
Are you under the care of a physician or mental health professional for any medical or psychological condition, which could affect your ability to care for clients 24 hours a day, 7 days a week?		
Do you take any prescribed medication, over the counter or herbal medicine, which might affect your ability to respond to clients 24 hours a day, 7 days a week?		
Do you become easily angered or quickly frustrated?		
Have you had a previous certificate or license to provide residential, social or healthcare services that was revoked and not successfully appealed within the last 12 months?		

Use this area to explain any areas above, attach additional sheets if necessary:

_____

_____

_____

_____

By signing below, I acknowledge I have answered all questions honestly and to the best of my ability. I verify that I can speak, read and write in the English language in order to communicate with Medical providers. I understand by not completing this form entirely and/or falsifying information can lead to denial of an application or revocation of any approval at a future date.

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

I understand the clients 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 I shall provide for social and recreational activities of the client based on their service plan.

I understand if any information on this form changes I need to give the Community Care Foster Family Home an updated copy.

_____ _____

SCG Full Name *(please print)*

_____

SCG's signature

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