Community Ties of Amercia, Inc. (CTA)

1 and 2 Bed CCFFH Substitute Caregiver Application

This form is to be used ONLY by a Substitute Caregiver (SCG) applicant who has NEVER been previously approved by CTA that will work ONLY in a 1 and 2 Bed Community Care Foster Family Home (CCFFH)

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

After the SCG receives CTA approval, the client's Case Management Agency must train the SCG on every client's service plan BEFORE providing care to any client.

CTA has 30 days to process this request from the date of receiving a complete application. All information on each line must be completely filled out and requested information attached to the form. The request will not be processed if the application is incomplete or missing requested information.

If approved, the SCG approval form will be mailed to the applicant. If the applicant's address is the same as the PCG's address, the SCG will also be added as a household member of the PCG, if not currently listed.

Please do not call CTA to inquire about your request until after 30 days to allow for processing.

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Fax the SCG Application to (808) 234-5470

SCG Applicant's Name: ______________________________ SCG's Phone: ____________________

SCG Mailing Address: ____

Date of Birth:__________ Age: _____ Applicant is a: NA CNA LPN RN <3 hour SCG

SCG Email address: ____________________________

ONLY the following is needed with this SCG Application:

- Current Fingerprint/APS/CAN results completed ***dated within 6 months of this SCG Application***.
- Copy of current NA certificate, CNA card, LPN or RN license (unless applying to be a less than 3 hour SCG)

NOTE: The PCG must maintain, in their CCFFH, all SCG related forms in their respective files.

By signing this application, I am accepting responsibility to follow all Department requirements per HAR 11-800 regulations. I verify that I can speak, read, and write in the English language and can communicate with Medical providers. I understand I must be trained by each client's Case Management Agency on each client's service plan, complete a basic skills check, and receive Nurse Delegation BEFORE I can provide care to any client. I understand that once approved, I can work in any 1 or 2 bed certified CCFFH.

Substitute Caregiver signature: ____ Date: ______________

Primary Caregiver's name the SCG will be initially working for ________________________________

PCG Address: ____ Phone: ______________

How many clients is the PCG currently certified to care for: __________

By signing this form, I understand I am completely responsible to ensure all requirements are maintained and up to date for this SCG. I am responsible to keep all records for the SCG in my home and ensure substitutes meet all yearly training requirements as listed in HAR 11-800 regulations. I also understand 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 adequately care for the clients in my home.

Primary Caregiver signature: ____ Date: ______________

*If your SCG Application is denied **you must resubmit everything**; not just the documents that were missing.*

Forms can be found at http://www.comties.com/ccffh-forms