## Community Ties of Amercia, Inc. (CTA)

Fax to: (808) 234-5470

# 3-Bed CCFFH Substitute Caregiver (SCG) Application

If approved, this SCG will be permitted to work in any DOH-approved 1, 2 or 3 Bed CCFFH. The SCG Approval will be mailed to the SCG so contact them for a copy. The SCG will be added as a household member of the PCG if both addresses are the same.

CTA has 30 days to process this request from the date of receiving a complete application. The application will not be processed if incomplete. Please do not contact CTA until after 30 days.

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

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.

**Complete this form in its entirety**.

## SUBSTITUTE CAREGIVER INFORMATION (*PLEASE PRINT CLEARLY)*:

Applicant's Name: _____ SCG's Phone: _____

Mailing Address: _____

Date of Birth: _____ Age: ___ Email Address: _____

Applying as a (**CHECK ONE**): NA CNA LPN RN

**FAX ONLY THESE DOCUMENTS TO CTA (*nothing else is needed*):**

- ☐ SCG Application
- ☐ Current Fingerprint/APS/CAN results **dated within 6 months of this SCG Application Date**
- ☐ Copy of the applicant's current NA certificate, CNA card, LPN or RN license
- ☐ Job Experience Form (must prove 1,920 hours of experience in no less than 12 months)
- ☐ Job Employment Verification Letter(s) from past employer to prove a minimum of 1920 hours

By signing this application, I am accepting responsibility for following 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 must receive Nurse Delegation **BEFORE** I can provide care to any client.

SCG Signature: _____ Date: _____

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## PRIMARY CAREGIVER INFORMATION (*PLEASE PRINT CLEARLY)*:

Name: _____ Phone: _____

Mailing Address: _____

I am certified to care for _____clients.

By signing this form, I understand I am completely responsible for ensuring all requirements are maintained and up to date for this SCG. I am responsible for keeping all records of my SCGs in my CCFFH and ensure my SCGs 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 take care of the clients in my home.

PCG Signature: _____ Date: _____

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