Community Ties of Amercia, Inc. (CTA)

Fax application to: 808-234-5470 for processing

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 incomplete or information is missing and the applicant will be contacted.

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

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

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

SCG Mailing Address: _____

Date of Birth: _____ Age: _____ Applicant is a NA, CNA, LPN, RN or <3 hour SCG (Circle one)

SCG Email address: _____

A copy of the following must be sent with this application

- Copy of the applicant's current NA certificate, CNA card, LPN or RN license (unless applying to be a less than 3 hour SCG)
- Current Fingerprint/APS/CAN results completed within the past 6 months

By signing this request form, I am accepting responsibility to follow all Department requirements per HAR 17-1454 regulations. I verify that I can speak, read and write in the English language in order to 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. 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 17-1454 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.

Primary Caregiver signature: _____ Date: _____