Substitute Caregiver Change Form

Do Not Send This Form To CTA.

This form will remain in the home's personnel records and will be reviewed by CTA during certification surveys as record of notifying the department of all SCG changes per the Hawaii Administrative Rule requirements. A home should keep all SCG records for all SCG's used by the home for each certification period including this form to show when a SCG was added and/or removed.

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

PCGs need to use this form when:
-- removing a SCG
-- adding a SCG who is already approved by CTA. A copy of the SCG approval must be obtained FROM THE SCG being added to the home, not CTA. PCG must keep SCG's initial CTA approval in CCFFH file.

This form is only to show CTA SCG changes that occurred between certification surveys. An SCG must receive nurse delegation from the client's case management agency before caring for clients.

Primary Caregiver's Name: _____

Substitute Caregivers Name: _____ DOB: _____

This SCG is a (*circle one*): <3 hr NA CNA LPN RN

Did the CCFFH remove or add this caregiver (*circle one*): ADDED REMOVED

If CCFFH added this caregiver, what date was the SCG approved by CTA: _____

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 SCGs 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: _____

If requesting to add a SCG, please have the SCG read and sign this statement:

By signing this 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 skill check and must receive nurse delegation before I can provide care to any client.

SCG's signature _____ Date: _____