Comanche Nation

Elderly Caregiver Program

Application

(The Elderly Have To Be Sixty (60+) Years And In Need Of Assistance)

CAREGIVER INTAKE FORM

Name:_____ Date:_____

Adress:_____

Tele #:_____ Social Security #_____

Mark the Service(s) that you are requesting:

Information ☐ Training ☐
Assistance ☐ Respite ☐
Counseling ☐ Supplemental ☐

Elder Information

Name:_____ Female ☐ Male ☐

Address:_____

Date of Birth:_____ County reside:_____

Social Security #:_____

Where will the care of the elderly/disabled person take place?

Elder's Home ☐ Caregiver's Home ☐ Other ☐

Source of Income:_____ Monthly Income_____

The Caregiver Program will have 12 weeks of assistance for Respite Care for the Elders starting on October 31, 2016 and eligibility will be for those that are in the greatest of need with the Activities of Daily Living and Instrumentals of Daily Living and Frailty- not able to provide care for themselves and cannot be left alone by themselves.

If there are other individuals living in the home with the elder then how many are living there:_____

If the applicant is under 60 years old, they need to be 100% disabled to be eligible for the Caregiver Program and they have to be receiving disability payments through the government.
How old is the disabled individual and is he/she 100% disabled that he/she need personal and basic care. (Please explain)

_____

_____

Confidentiality and Disclosure of information: No information obtained from a participant by this program will be disclosed in a form that identifies that person without the consent of the person or his legal representative, unless the disclosure is required by a court order or for the program monitoring by the federal funding agencies or tribal requirements.
No information will be disclosed that is exempt from disclosure by a Federal Agency under the Freedom of Information Act, 5U.S.C.502.

Acknowledgment:_____ Date:_____

**** RECIPIENT BASIC INFORMATION****

NAME : _____

DATE OF BIRTH _____

SOCIAL SECURITY # : _____

SPOUSE/FRIEND/RELATIVE LIVING IN THE HOME _____

HOME TELEPHONE: _____

ANOTHER CONTACT PERSON: _____

TELEPHONE #: _____

**** EMERGENCY TELEPHONE NUMBERS ****

PRIMARY PHYSICIAN: _____

ADDRESS: _____

TELEPHONE: _____

PREFERRED HOSPITAL: _____

PHARMACY: _____

TELEPHONE: _____

Respite Provider Employee Application

Name:_____

Address:_____

Date Of Birth:_____

Social Security #:_____

Telephone:_____ Cell Phone:_____

Education Level:_____

Training/Certification:_____

Do you have CPR/FIRST AID:_____

Are you available to work Monday to Friday:_____

Do you have transportation of your own:_____

Do you have a valid driver's license:_____

Do you have a valid car insurance:_____

Would you object to a drug test:_____

What would you do in case of an Emergency:_____

_____

How would you get an elder to cooperate with you:_____

_____

Name of the Elder that you are providing care for:_____

Signature of Respite Provider:_____

Date:_____

Client Assessment

Requires assistance with activities of Daily Living and needs to have two to be eligible. Check all that apply:

Eating: ☐ Dressing: ☐ Bathing: ☐

Transferring: ☐ Toileting: ☐ Incontinence: ☐

Requires assistance with two Instrumental ADLs. Check all that apply:

Preparing Meals: ☐ Housework: ☐

Laundry: ☐ Prescription Medication: ☐ Distance Walking: ☐

Shopping: ☐ Managing Money: ☐ Using Telephone: ☐

Requires supervising due to Alzheimer's Disease or Dementia: ☐

Chronic conditions that lead to Disability: Check all that apply:

Heart Disease: ☐ Stroke: ☐ Diabetes: ☐ Pulmonary Disease: ☐

Affecting Functioning Ability: ☐ Osteoporosis: ☐ Hearing Loss: ☐

Vision Loss: ☐ Orthopedic: ☐ Hypertension: ☐

Please check if the recipient receives the following:

Hospice: ☐ Home Health: ☐ DHS Services: ☐ Nutritional Meals from Comanche Nation Elder Center: ☐ CHR Services: ☐

Does the recipient need assistance with the following items:

Wheelchair: ☐ Walker: ☐ Cane: ☐ Hearing Aid: ☐ Other: ☐

COMANCHE NATION
CAREGIVER PROGRAM
(580) 492-3282

Person's Name:_____ Date of Birth:_____
Address:_____

TO BE FILLED IN BY THE DOCTOR: An application has been made to this office for services for the individual named above.
In order to provide needed services, the information regarding the disability, health conditions and the following questions need to be filled out in this form and returned to the address above.
Please call if you have any questions.
What is the disability:_____
What is the diagnosis for the disability:_____

_____

In your professional judgment is this disability likely to continue indefinitely or will the individual recover better health conditions

_____

_____

Does the person require (Indicate yes or no)
Supervision of activities of Daily Living? If yes, please describe:

_____

_____

Does this person need personal care?_____ If yes, please describe

_____

Is this person in need of skilled care, if yes please describe_____

_____

Medications and reasons prescribed_____

Special needs of the individual_____

_____

Signature of the Physician_____
Name of the Physician (Please Print)_____
Address_____
Telephone_____

RESPITE CONTRACT SERVICE
AGREEMENT AND RESPONSIBILITIES

1,_____ agree to the terms of this agreement and enter into an agreement to provide contractual service with the Comanche Nation Caregiver Program.

I, understand that I am eligible to receive Respite Services for two times a year basis however I have to Renew this agreement and provide a statement explaining the reason additional care is needed.

I have the responsibility to provide Respite care for 12 weeks of assistance for Mondays, Wednesdays and Fridays for 2 hours a day at $10.00 an hour and paid every 2 weeks.

I, agree to the terms of this agreement with the following conditions:

- By submitting timesheets to the Caregiver Program that includes hours, rate of pay and total amount due with all signatures and dates verifying and approving for payment every (2) weeks with payment due on the following Friday.
- That no copies made on another computer, and pick up timesheets at the Caregiver Office, only.
- That no changes or modification be made to this agreement.

RESPITE CONTRACT SERVICE DATA

Name:_____ Social Security #:_____

Address:_____ Pho #:_____

_____

Respite Provider Signature:_____ Date:_____

ADMINISTRATIVE APPROVAL

Date for Respite Care:_____

Date to End Respite Care:_____

Director's Signature:_____ Date:_____

Comanche Nation Caregiver Program
5 SW D Avenue, Suite A, Lawton, OK 73501

Pho: (580) 699-8811/ (580) 699-8812
Fax: (580) 699-8815

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			-		-				

Employer identification number

		-							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

Employment Information

Would you object to the Caregiver Program to inquire

About you employment with them.

Yes ☐ No ☐

Tribal Employee: Yes ☐ No ☐

Department: _____

Title: _____

Phone Number to Business: _____

WIA Employee: Yes ☐ No ☐

Job Location: _____

Title: _____

Phone Number to Business: _____

Are you a permanent employee with another company or agency or some other Tribe?

Department : _____

Title: _____

Phone Number to Business: _____

Submit by E-mail