Comanche Nation Elder Center

Programs Goals & Objectives

Our goal is to improve the quality of life for elderly Native American's and to provide well balanced meal that meets the Dietary Guidelines for Americans (DGA's) published by DHHS and the USDA in a congregate, drive-thru and home-delivered setting to elders 60 years and older living within our servicing area. (The CNEC services Comanche, Cotton, Tillman, and portions of Stephens, Jackson, and Jefferson Counties). We provide information and referral services to identify resources to meet the needs of our clients.
Objectives of the Elder Program is to provide the opportunity for older Americans to live their years in dignity by:

- Providing healthy and appealing meals
- Providing healthy lifestyle information and training
- Reducing social isolation by increasing daily social interaction and activities
- Referrals to tribal and non-tribal services that provide activities programs, community health, or case management services.
- Provide information and referral services to meet the elders needs
- Any changes in household, address, or phone number must be reported within 30 days of the change.

Eligibility Requirements

Must be a member of a federally recognized tribe, 60 years of age and older, handicapped or disabled, low-income, or at-risk of becoming socially isolated to be eligible for meal services. All participants are required to complete an intake form for congregate/drive-thru meals and home-delivered meals. ALL participants must provide CDIB and proof of residency **(HOME DELIVERED CLIENTS MUST PROVIDE Rx or DR REFERRAL)**.

- All participants must be an enrolled member of any tribe 60 years of age or older.
- A spouse of participant of any age and can be non- Indian. Should a spouse become widowed, the spouse shall remain eligible for meal services unless they remarry.
- Handicapped or disabled individual do not have to meet age requirements but, need to provide documentation & reside in a home of an elder to meet the criteria.
- Caregiver (regardless of age) that provides escort to an elder who is disabled for the noon meal, will not be required to pay meal cost. This will include getting the meal and refreshments for the disabled elder.
- Guest will be required to pay $5.00 for the noon meal. Guest (anyone other than those eligible for the program) will be charged the full cost of the meal.
- **All participants are required to up-date applications annually (Every October, ALL participants must submitt an updated application, homebound participants must submit a new RX from their physician) failure to do so will result in removal from the delivery program.**

Please note that there will be quarterly program surveys and an annual application update sent out to all of our clients. These surveys and updates will be used to help us determine client needs and program eligibility.

(PLEASE NOTE: AT NO TIME CAN ANY PARTICIPANT RECIEVE MEALS FROM MORE THAN ONE LOCAL NURTITION CENTER, THIS IS GROUNDS FOR REMOVAL FROM OUR PROGRAM)

Confidentiality: Information about the participant or obtained from a participant by the program will not be disclosed to any outside party without the informed consent of the client. Information may be exchanged between department heads, federal and state agencies for eligibility purposes.

Comanche Nation Elder Center

MEAL APPLICATION

APPLICANT INFORMATION (INCOMPLETE APPLICATIONS WILL NOT BE ACCEPPTED)

Client Name:		
DOB:	CDIB#	Phone:
Address:		
City:	State:	ZIP Code:
Housing Information: Rent Own	☐ House ☐ Apartment ☐ Other	Do you own a dog? ☐ Yes ☐ No
Directions to Home:		

CAREGIVER AND/OR EMERGENCY CONTACT

Caregiver Name:		
DOB:	CDIB:	Phone:
Address:		
City/ State:	Zip Code:	Relationship to client:
Are you paid to care for the client? ☐ Yes ☐ No	Do you drive? ☐ Yes ☐ No	
Housing Information: Rent Own	☐ House ☐ Apartment ☐ Other	
Do you own a dog? ☐ Yes ☐ No		

HOUSEHOLD INFORMATION (PLEASE LIST ALL FAMILY MEMBERS, DO NOT LIST INCOME "$" AMOUNT)

NAME	DOB	TRIBAL AFFILATION	SOURCE OF INCOME (SSI, DISABILITY, EMPLOYED)
(Example) John Doe	00-00-1234	Comanche	SSI

MEDICAL HISTORY

PLEASE LIST CHRONIC ILLNESSES:	
PHYSICIAN NAME:	PHYSICIAN PHONE:

SERVICE REQUESTED

☐ DELIVERED MEALS: (Must have physicians recommendation for home delivered meals)

☐ DRIVE-THRU MEALS (Must Have a completed application on file)

☐ CONGREGATE MEALS (When available, must Have a completed application on file)

TRANSPORTATION

☐ Provides own transportation	☐ Rely on family or friends	☐ Tribal/ public transportation

By signing below I am agreeing to the policies and guidelines of the Comanche Nation Elders Center meal program, I am aware that any false information could cause me to be removed from the program.
DATE:

PRINTED NAME:	SIGNATURE:

HOMEBOUND CERTIFICATION

Home Delivered Nutrition Services are targeted to persons 60 years of age or older. Priority shall be given to older individuals with greatest economic and social need, with special emphasis on low-income minority individuals, older individuals with limited English proficiency, older persons residing in rural or geographically isolated areas, and older individuals at risk for institutional placement.

In order to be certified as homebound you must have your Physician sign the following statement.

Homebound is defined as, because of illness or injury, the need and the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person is required to leave their place of residence. This means there is a inability to leave home with out assistance, or the participant has a medically diagnosed condition that prevents them from leaving their home. Leaving home must require a considerable and taxing effort.

I _____ physician at _____ do hereby certify that _____ meets the HOMEBOUND requirements set forth by the Comanche Nation Elder Center and the Title VI ACL federal program guidelines.

I also acknowledge that this homebound certification will be re-evaluated annually.

Signature _____ Title_____ Date _____

Duplication of Services Acknowledgment

(To be filled out by program participant)

I certify that I _____ do not receive meals from any other meal program (tribal or non-tribal).

I acknowledge that if I am identified as knowingly receiving nutrition services, in the form of meals from any other entity, I will be removed from the program indefinitely.(initials____)

I also acknowledge that if I choose to utilize another elderly meal program that I will notify the Comanche Nation Elderly Center and ask to be removed from the program. (initials____)

Signature _____Date _____