Comanche Nation Native American Caregivers Support Program Application (Title VI Part C)

Located at
Comanche Nation Elder Nutrition Center
1107 S. H Avenue
Lawton Oklahoma 73501
Office: 580-355-2330
Fax: 580-355-2365

Documentation Needed to Complete your Application

Care Receiver: _____

*Must be **at least 60 yrs. or older**
*Identification
*CDIB (Must be Native American)
*Medicare Card or Insurance Card
* **MUST** have Documentation of Illness or Physician's Statement

Care Giver: _____

*Primary Care giver to Care Receiver, who is **non-paid**
*Identification
*Does Not have to be Native American

Respite Provider: _____

*Identification (must be over 18)
* Social Security
* Proof Of Address (Due to Federal Guidelines, the Respite **CANNOT** reside in the same Household as Care Receiver)
* Person who is **PAID** to relieve Caregiver.

COMANCHE NATION TITLE VI CSP CAREGIVER/ RESPITE CONTRACT/AGREEMENT

____Caregiver Support Program (CSP) ____Terminal Tribal Members (TTM) (62 and under)

I, _____Caregiver agree to the terms of this CSP agreement and enter into agreement with the Comanche Nation Title VI Caregivers Support Program to provide contractual services. Services on behalf of Care Receiver_____ agree to Respite Provider services _____.

I understand that I may be eligible for Respite Services on a yearly basis and services are from Monday thru Sunday 24/7 care. Respites are paid per quarter (3) three months and after the quarter they are referred to other state respite agencies. The family members of the Care Receiver choose the Respite Provider. [The frail is defined as unable to perform at least two ADLs or have a cognitive or other mental impairment requiring substantial supervision]. I will renew the agreement if additional care is needed for the frail elder. Statements from the health care provider will explain what additional care if needed for approval.

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

Respite must be over the age of 18 and not reside in the home of the Care Receiver.

Respite agreement for providing personal support will begin on _____ and will be finished on _____. The respite provider will be paid at a rate of $8.00 per hour for less care and more care $10.00 per hour.

Respite Provider agrees to follow the responsibilities listed in this agreement & Policies and Procedures and agrees to the follow the support plan that has been developed by the family.

The Respite Provider will ensure that all information will be kept private and confidential.

CSP Program **does not pay mileage** to Respite Providers services.

The Respite Provider must submit a time sheet to the Director/CSP Coordinator and all paper work to be verified by the Caregiver to ensure it is correct and both parties will sign for approval for payment. Time Sheets should be readable & signed by both parties and due every two weeks.

If any information is released without the consent of the family/Caregiver, this would be grounds for immediate dismissal.

Cannot obtain services from the other Caregiver Program while in contract with CSP.

Terms of Payment

The Respite Provider is responsible for keeping a record of the hours worked on a timesheet and must be readable to process. This timesheet/proof of service is to be submitted to the family contact for signing every (2) two weeks beginning _____. The Respite Provider will maintain full responsibility for keeping a record of earnings and declaring this/her income for income tax purposes and understand anything earned over $300 dollars the Respite Provider will have to do a 1099 Form. The Respite Provider is NOT AN EMPLOYEE OF THE COMANCHE NATION or FAMILY/GUARDIAN.
The Caregiver/Care Receiver has the right to change this agreement with written notice. This agreement may be finished without notice if anytime this contract cannot be completed, or the Respite Provider did not do skills/abilities necessary for the well-being of _____, Care Receiver. Must use blue or black ink when signing any paperwork for this program.

"I agree to provide support services as outlined in this agreement."

Signature of Respite Provider : _____ Date _____

Signature of Caregiver/Care Receiver : _____ _____ Date _____

Respite Information:
Name: _____ Social Security #: _____
Address: _____ Contact Number: _____
City/State/Zip Code: _____
Respite Provider Signature: _____

Office Approval

Director/Coordinator Signature: _____ Date: _____

Is this application approved: ____ Yes ____No If not approved, why: _____
_____
_____

Caregiver Information (Person requesting the respite)

Please type or print in Black or Blue Ink

Name (first middle last):_____

Mailing Address:_____City_____State:_____ Zip:_____

County of Residence: _____ **Contact Number** (_____)

_____

Relationship to Care Receiver:

_____Daughter/Son
_____Spouse
_____Brother/Sister
_____Niece/Nephew
_____Grandparent
_____Grandchild
_____Parent/Step-parent
_____Step-daughter/Step-son
_____Other, specify

Why are you requesting respite? (required information:

_____
_____
_____
___

Caregiver Information

[The following information is optional and for demographic purposes only]

Age of Caregiver: _____ Education (highest grade completed): _____

Employment Optional:

___ Full time employed (35 or more hours/week) ___ Full time student
___ Part time employed (less than 35 hours/week) ___ Part time student
___ Unemployed ___ Other (specify) _____

Sex: **Number of Household Members:**

___ Female ___ Male _____Adults _____Children

Care Receiver Information (Person needing care)

Name (first middle last):_____

Address:_____

City: _____ State: _____ Zip Code: _____

County: _____ Date of Birth: _____/ _____/ _____

Care Receiver must be **Native American** and have a **Certificate of Tribal Blood (CBIB)**. What is

your Tribal Affiliation? _____ CDIB: _____
_

Is the Care Receiver:

The Care Receiver …. **[Check all that apply]**

_____Has special/chronic health care needs
_____Receives SSI
_____Has Alzheimer's Disease or other dementia
_____Receives other services through the OK Department of Human Services
_____Has Acquired Brain Injury
_____Has developmental disabilities
_____Is an elderly, dependent adult (age 60 or older?)
_____Is enrolled in a Medicaid Waiver Program such as CBA or Class?
_____Is grandchild being raised by grandparent?

Applicant agrees to the Comanche Nation Caregivers Support Program and all other agencies participating in this program are providing not direct or indirect services, and the applicant shall hold harmless and indemnify these agencies for any damages or liabilities it incurs arising from this agreement.

Caregiver's Signature _____Date _____

Consent to Release Information

Please Print Clearly

I, the care receiver OR their representative, give permission for the Comanche Nation Title VI Caregivers Support Program to contact the following organization or individuals so that those involved with my care can communicate and work together on planning for me to receive respite care. This is valid through _____, The enclosed medical and personal information may be sent to or shared with the following:

Respite Provider: _____

Address: _____

Phone: _____ **Email Address**: _____

Additional or Alternate Respite Provider: _____

Address: _____

Phone: _____ **Email Address**: _____

OR

Initial [ ] We do not yet know which agency or adult day care or other program we will use, but we do agree to allow the Comanche Nation Title VI Caregivers Support Program to provide our information to the one on which we agree as we negotiate the best place for our respite services, with the understanding that only those who need to know will receive the information and will keep it confidential.

Printed Name (Parent/Guardian/Caregiver) _____

Signature _____ **Date** _____

Person receiving care, (if they can sign)_____

Printed Name _____

Signature _____ **Date** _____

Caregiver Self-Assessment

Respite = regular, short-term breaks for the main caregiver of someone of any age who has special needs.

What do you hope to get from having this voucher for respite? [ ] just some time to myself

[ ] a vacation [ ] some time with other family without our loved one with special needs

[ ] a good night's sleep [ ] catch up some medical and other appointments for me

[ ] other (please explain) _____

_____

_____

_____

Caregiver Signature: _____ Date:_____

Professional Certification Form

Comanche Nation Title VI Caregivers Support Program is a Federal Program working on respite for all family caregivers with a grant awarded to Indian Tribal organizations representing federally recognized Tribes and public or non-profit private organizations that have the capacity to provided services to Native American Elders age 60 and older under Parts A and B and family caregiver support services under Part C. In the OAA Older Americans Act Amendments of 2000, Part C, the Native American Caregiver Support Program was added, the program provides respite vouchers. Your patient/client's family has requested a respite voucher.

The signatures below indicate their consent to have you release the request information.

Name of Parent/Guardian/Family Caregiver: _____

Signature: _____ Date: _____

Name of Care Receiver [person receiving care]: _____

Date of Birth [Care Receiver]: _____

Signature [if able]: _____ Date: _____

Address: _____ Phone # _____

_

THIS SECTION TO BE COMPLETED BY QUALIFIED PROFESSIONAL ONLY

[Doctor, Licensed Nurse, Licensed Therapist, Social Worker, or Case Manager. We do not accept a form completed by CNAs].

Please indicate the ability level for each activity: 0 to 5 (0 = independent) 5 = (totally dependent)
Ambulation _____ Transferring _____ Bathing _____
This person is bedbound _____No _____Yes

This patient/client is incontinent [ ] bladder [ ] bowel [ ] neither
This person has [ ] dementia [ ] difficult behaviors [ ] seizure disorder
Due to cognitive or other mental impairment, the care receiver requires moderate to substantial supervision because their behavior poses a health or safety hazard to them self or others?
Yes [ ] No [ ] Cognitive Diagnosis: _____

In your professional opinion is this care receiver able to be left alone without supervision or assistance for any length of time [i.e. several hours]? Yes [ ] no [ ] overnight yes [ ] no [ ]
Diagnosis/other Info:
_____

Completed by Professional [printed date]: _____

Title: _____ Discipline: _____

Name of Practice: _____

Address: _____Phone: _____

City: _____ Zip Code: _____ Fax # _____

Professional Signature: _____ Date: _____

RESPITE TIME SHEET

(Due Every Two Weeks)

Pay Period 04 / 02 / 18 to 04 / 13 / 18

A[illegible]natures must be obtained at the end of every (2) weeks. Forging signatures is against the law [illegible] p[illegible]ation obtained is actual proof of Respite Services provided. My signature indicated that the inf[illegible] contained on time sheet is true and accurate to the best of my knowledge.

RESPITE NAME: _____

Respite Signature	*04/13/18*	*Respite Signature*	*Caregiver Signature*	*04/13/18*
Respite Provider	*Date*		*Caregiver/ Receiver*	*Date*

Day	Date	Location	Start Time	End Time	Total Hours	Authorized Signature
Sunday	*04/02/18*	*Care Receiver Home*	*2pm*	*3pm*	*1 Hr*	*Care Giver Signature*
Monday	*04/03/18*	*Care Receiver Home*	*2pm*	*3pm*	*1 Hr*	*Care Giver Signature*
Tuesday						
Wednesday	*04/05/18*	*Care Receiver Home*	*8am*	*9am*	*1 Hr*	*Care Giver Signature*
Thursday	*04/06/18*	*Care Receiver Home*	*9am*	*10am*	*1 Hr*	*Care Giver Signature*
Friday	*04/07/18*	*Care Receiver Home*	*11am*	*12noon*	*1 Hr*	*Care Giver Signature*
Saturday						

Day	Date	Location	Start Time	End Time	Total Hours	Authorized Signature
Sunday						
Monday	*04/09/18*	*Care Receiver Hm*	*9 am*	*10 am*	*1 Hr*	*Care Giver Signature*
Tuesday	*04/10/18*	*Care Receiver Hm*	*9 am*	*10 am*	*1 Hr*	*Care Giver Signature*
Wednesday	*04/11/18*	*Care Receiver Hm*	*9 am*	*10 am*	*1 Hr*	*Care Giver Signature*
Thursday	*04/12/18*	*Care Receiver Hm*	*9 am*	*10 am*	*1 Hr*	*Care Giver Signature*
Friday	*04/13/18*	*Care Receiver Hm*	*9 am*	*10 am*	*1 Hr*	*Care Giver Signature*
Saturday						

RESPITE TIME SHEET

(Due Every Two Weeks)

Pay Period ____/_____/____ to _____/_____/_____

Authorized signatures must be obtained at the end of every (2) weeks. Forging signatures is against the law [illegible] policy. Information obtained is actual proof of Respite Services provided. My signature indicated that the information contained on time sheet is true and accurate to the best of my knowledge.

RESPITE NAME:_____

Day	Date	Location	Start Time	End Time	Total Hours	Authorized Signature
	Respite Provider	*Date*		*Caregiver/ Receiver*		*Date*
	Respite Provider	*Date*				
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						

Day	Date	Location	Start Time	End Time	Total Hours	Authorized Signature
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						