Comanche Nation Native American Grandparents Raising Grandchildren 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

Grandchild/ren: ______________________________

* Grandchild must be under 18 years of age
* CDIB (Must be Native American)

Care Giver: ______________________________

* Must be at least 55 or older
* Primary Care Giver to Grandchild/ren, who is **non-paid**
* Identification
* Does Not have to be Native American
* Must have legal custody or signed statement from child's parent(s)

Respite Provider: __________________________

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

COMANCHE NATION TITLE VI CSP GRANDPARENTS RAISING GRANDCHILDREN/ RESPITE CONTRACT/AGREEMENT

I, ____________________________________ Grandparent agree to the terms of this CSP agreement and enter into agreement with the Comanche Nation Title VI Caregivers / Grandparent Raising Grandchildren Support Program to provide contractual services. Services on behalf of Grandchild/ren __________________________ 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. I agree to the terms of agreement with the following conditions:

Respite provider 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. One hour per day for five days a week, not to exceed 5 hours per week.

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 Comanche Nation Native American Support Program.

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 CONSIDERED AN EMPLOYEE OF THE COMANCHE NATION** or FAMILY/GUARDIAN. The Grandparent /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 _________________________________ 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: ____________________

____

____

Grandparent (s) 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:
____
____
____
___

Grandparent 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** _______________________________

Grandparent 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) ____

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____

____

Caregiver Signature: ___________________________ Date:___________________________