COMANCHE NATION

ELDER CAREGIVER PROGRAM

APPLICATION

(The Elder must be 62 years of age or older and in need of assistance)

CAREGIVER INTAKE FORM

NAME: _____ DATE: _____

Address: _____

Tele #: _____ Social Security#: _____

Mark the Service(s) you are requesting:

Information _____ Training: _____

Assistance: _____ Respite: _____

Counseling: _____ Supplemental: ____

ELDER INFORMATION

Name: _____ Male: _____ Female: _____

Address: _____

Date of Birth: _____ County of Residence: _____

Social Security #: _____

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

Elder's Home: _____ Caregiver's Home: _____ Other: _____

Source(s) of Income: _____ Monthly Income: _____

The Caregiver Program will have 12 weeks of assistance for Respite care for the Elders. Eligibility will be for those in greatest need with the Activities of Daily Living and Instrumentals of Daily Living and Frailty – not able to care for themselves and cannot be left by themselves.

Please list other individuals living in the household:

_____ _____

_____ _____

_____ _____

Disabled

If the applicant is under 62 years of age, they must be 100% disabled to be eligible for the Caregiver Program and they must be receiving disability payments through the government.

How old is the disabled individual and is he/she 100% and in need of 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 their 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: _____

Birth Date: _____

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: _____

Home Telephone : _____

Another Contact Person: _____

CAREGIVER EMPLOYEE APPLICATION

Name: _____

Address: _____

Date of Birth: _____ Social Security #: _____

Telephone #: _____ Cell: _____

Education Level: _____

Training/Certification: _____

Do you have CPR/First Aid? Yes ___ No ___

Are you willing to take this training Yes ___ No ___

Are you available to work Monday to Friday: Yes ___ No ___

Do you have transportation of your own? Yes ___ No ___

Do you have a valid driver's license? Yes ___ No ___

Do you have car insurance? Yes ___ No ___

Would you object to a drug tests? Yes ___ No ___

What would you do in case of an emergency? _____

_____

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

_____

Name of Elder you will be providing care for: _____

Signature of Caregiver: _____ Date: _____

CLIENT ASSESSMENT

Requires assistance with activities of Daily Living (needs 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 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 Heath: _____ DHS Services: _____ CHR Services _____

Meals from Comanche Nation Elder Center _____

Does the recipient need assistance with the following items:

Wheelchair: ___ Walker: ___ Cane: ___ Hearing Aid: ___ Other ___

COMANCHE NATION
CAREGIVER PROGRAM
5 SW D Ave., Lawton, OK 73502
(580)699-8811

Elder's Name: _____ Date of Birth: _____

Address: _____

TO BE FILLED IN BY THE DOCTOR: 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 on this form and returned to the above address. 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 this person require 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:
_____

_____

Elder's Name (page 2) _____

Medications and reasons prescribed: _____

_____

_____

_____

Special needs of the individual: _____

_____

_____

Signature of Physician: _____

Name of Physician: (Please Print) _____

Address: _____

Telephone: _____

Thank you for your assistance.

RESPITEW CONTRACT SERVICE
AGREEMENT AND RESPONSIBILITIES

I, _____ agree to the terms of this agreement and enter into agreement to provide contractual service with the Comanche Nation Caregiver Program., understand I am eligible to receive Respite Services on a twice-a- year basis but I have to renew this agreement and provide statements explaining the reason additional care is needed.

I have the responsibility to provide Respite care for 12 weeks of assistance with payment on Monday, Wednesdays and Fridays for 2 hours a day at $10 an hour, paid the following Friday.

.I agree to the terms of this agreement with the following conditions.

Timesheets are submitted to Caregiver Program to include hours, rate of pay and total amount due with all signatures and dates verifying and approving for payment every 2 weeks and payment due on the following Friday.

No copies of the timesheets will be made on another computer. Timesheets will be picked up at the Caregiver office only.

No changes or modifications will be made to this agreement.

RESPITE CONTRACT SERVICE DATA

Name:_____ Social Security # _____

Address: _____

Home Phone #: _____ Cell Phone # _____

Respite/Caregiver Signature: _____Date: _____

ADMINISTRATIVE APPROVAL

Date to start Respite Care: _____

Date to End Respite Care: -_____

Director's Signature: _____ Date: _____

Comanche Nation Caregiver Program Phone # (580) 699-8811