Comanche Nation Title VI
Caregivers Support Program Guidelines

Family Caregiver: Is an adult family member or another individual who is an unpaid informal provider of in-home and community care to an older individual or to an individual with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction.

- Documents needed: CDIB's elder, child(ren) and/or caregiver, drivers license, and proof of addresses of all applicants.
- Respite must be over the age of 18.
- Respite **Cannot** reside in the same household as caregiver.
- Respite provider will be paid at the rate of $10.00 per hour and 10 total hours max weekly.
- Program term is 90 days, program participants will be eligible to apply again for services in 6 months.
- CSP Program does not pay mileage to respite provider for services.
- The Respite Provider will sign a confidentiality agreement to ensure that all information will be kept private and confidential. If any information released without the consent of the family/caregiver, this will be grounds for immediate dismissal.
- The Respite Provider must submit time sheet to the Director and all paperwork to be verified by the Caregiver to ensure it is correct and both parties will sign for approval for payment at the end of the 2-week period.

Grandparent or older individual who is a relative caregiver: a grandparent or a step grandparent of a child, or a relative of a child by blood, marriage or adoption, who is 55 years of age or older and,

- Lives with the child;
- Absent parent(s) may not reside in the same home as the caregiver.
- Is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and
- Has a legal relationship to the child, as such legal custody or guardianship, or is raising the child informally.

Caregivers cannot obtain services from other Caregiver programs while with CSP: We will provide a stipend, help caregivers with referrals and information regarding available community resources, support groups, training on various topics that pertain to care -giving and respite and supplemental services.

MISSION

The Native American Caregiver Support Program is a federally funded program provided by the Administration on Aging (AOA) Title VI Part C. The Caregiver Support Program is an organization of the tribal government whose intent is to provide services to the Native American caregivers within the tribal service area.

This program is to provide services for caregivers who serves elders 55 years of age and older and children under the age of 18. This program serves those caregivers by providing training and respite services. It is our intent to improve the quality of life to our families and tribal members.

The program enhances our tribal communities for further generations, as we honor our elders and children by ensuring the utmost care provided.

SUPPORT SERVICES

- Information to caregivers about available services
- Assistance to caregivers in gaining access to services
- Counseling, Training, Support Groups
- Respite
- Supplemental Services (supplies, care package, nutrition assistance)
- Lending Closet

RESPITE WORKER RESPONSIBITIES

- **To provide respite service to the caregiver:**
  The time and dates of work will be scheduled by the caregiver. If you are unable to fulfill this responsibility please notify the caregiver as soon as possible. The scope of work is also agreed upon by you and the caregiver. Please be sure you understand and agree with what responsibilities you are asked to do before signing the CONTRACT AGREEMENT.
- **To participate in any training or informational sessions:**
  Training sessions will be available to all respite workers; if needed.
- **To discuss with your caregiver any problems or concerns:**
  Your caregiver is your supervisor.
- **To provide a complete and accurate Respite time sheet:**
  Please ensure your time sheet is completely filled out with the correct times, dates, and signatures.
- **To complete and submit the IRS W-9 Form.**

Comanche Nation Elderly Center

CAREGIVER SUPPORT PROGRAM

TITLE VI PART C

APPLICATION FOR SERVICES

CAREGIVER NAME:		
DOB:	CDIB #	PHONE:
ADDRESS:		
CITY:	STATE:	ZIP:
REALATIONSHIP TO ELDER/CHILD:		
REASON REQUESTING SERVICES:		

CARE RECEIVER INFORMATION

ELDER/CHILD NAME:		
DOB:	CDIB #	PHONE:
ADDRESS:		
CITY:	STATE:	ZIP:

THE CARE RECEIVER: **(CHECK ALL THAT APPLY)**

___Has special /chronic health issues
___Receives SSI
___Has Alzheimer's Disease or other
___Has Acquired Brain injury
___Has developmental disabilities
___Is a grandchild being raised by grandparent

Elders must be 60 or older and unable to perform at least two Activities of Daily Living listed:

___Requires Supervision-Cognitive or mental impairment
___or limited due to illness, frailty, cannot manage independently
___Walking without assistance
___Dressing
___ Bathing
___ Eating
___ Transferring

RESPITE PROVIDER

RESPITE PROVIDER NAME:		
DOB:	CDIB #	PHONE:
ADDRESS:		
CITY:	STATE:	ZIP:
SS#	DL#	STATE ISSUED:
RELATIONSHIP TO CAREGIVER:		
RELATIONSHIP TO ELDER/CHILD:		

HAVE YOU EVER BEEN CONVICTED OF A FELONY? _____YES ____NO
If yes, please indicate the crime(s), jurisdiction of adjudication, and date(s) of conviction:

ARE YOU CURRENTLY CHARGED WITH A CRIME OTHER THEN TRAFFIC VIOLATION? _____YES ____NO
If yes, please indicate the crime, jurisdiction of adjudication, and current status of the crime:

***PLEASE NOTE, A FAILURE TO DISCLOSE CRIMINAL CONVICTIONS MY RESULT IN THE APPLICATION BEING WITHDRAWN FROM CONSIDERATION OR DISQUALIFICATION OF PARTICIPATION. ***

CAREGIVER SIGNATURE: **DATE:**

RESPITE PROVIDER SIGNATURE: **DATE:**

RESPITE CONTRACT SERVICE AGREEMENT AND RESPONSIBILITES

I, _____ (respite worker) agree to the terms of the contract and enter into an agreement to provide contractual service

with _____, (caregiver).

I agree to provide Respite Care, upon the approval date of this contract; at the rate of $10.00 per hour.

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

1. I will invoice the CSP of the work hours, rate and total amount due.
2. I will ensure the invoice is signed by both Caregiver and Respite worker.
3. I will submit the W-9 IRS Form with the initial Agreement.
4. I acknowledge that no change or modification will be made to this agreement.
5. I acknowledge that this contract will not exceed the allocated amount $200.00 per pay period.
6. I acknowledge certain information revealed from the respite worker background check may be disclosed to determine eligibility for program participation.

I understand that from time to time the Comanche Nation CSP may review the terms of my service. I also understand that this contract may, at any time, be terminated by the Caregiver of Comanche Nation CSP.

Respite Contract Worker

Printed Name: _____

Signature: _____ Date: _____

Caregiver

Printed Name: _____

Signature: _____ Date: _____

TRANSPORTATION LIABILITY WAIVER

The Comanche Nation Caregiver Support Program does not verify drivers license, proper insurance or registration for respite workers participating in the program.

By signing below, I acknowledge that driving is an inherently risky activity that could result in severe injury or death. I acknowledge that I am responsible for my driver's license and automotive insurance, during anytime that my vehicle is in use, providing respite services to the caregiver.

I agree that the Comanche Nation Tribe or the Comanche Nation Caregiver Support Program, or any of its employees of those entities shall not be held liable in the event of any accident causing damage to vehicles, other property damage, or personal injury to anyone involved in an accident.

PRINTED NAME/RESPITE WORKER: _____

SIGNATURE: _____

DATE: _____

INSURANCE CARRIER: _____

POLICY NUMBER/EXPIRATION DATE: _____

DRIVERS LICENSE #/STATE ISSUED: _____

CAREGIVER PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

COMANCHE NATION CAREGIVER SUPPORT PROGRAM

CONFIDENTIALITY AGREEMENT

I _____, (respite worker) agree to the following:

No information about a participant will be disclosed by this program without the informed consent of the participant or his/her legal representative, unless the disclosure is required by court order or for program monitoring by Federal funding agencies.

I understand that I my come into contact with confidential information during my time with Comanche Nation CSP. As part of the condition of my work with the CNCSP I hereby undertake to keep in strict confidence any information regarding the Caregiver/ Care Receiver. I will do this in accordance with the CNCSP privacy policy.

I also agree to never remove any confidential material of any kind from the premises of the CNCSP unless authorizes as part of my duties, or with the permission or direction to do so.

PRINTED NAME/RESPITE WORKER: _____

SIGNATURE: _____

DATE: _____

CAREGIVER SURVEY

1. I have been a caregiver for:

☐ Less than a year ☐ 1-5 years ☐ 6-9 years ☐ 10 or more years

2. I care for my:

☐ Spouse ☐ Parent ☐ Child ☐ Grandchild ☐ Other: _____

3. The age of my recipient is:

☐ 18 & under ☐ 60-69 ☐ 70-79 ☐ 80-89 ☐ 90 & over

4. My Care recipient lives:

☐ In their own home ☐ with family ☐ with friends ☐ Other: _____

5. The following would benefit me a caregiver:

☐ Support groups ☐ Respite care ☐ Support by phone ☐ Community Presentation

6. I work outside of the home

☐ Yes ☐ No

7. My sleep is affected by stress and responsibility:

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

8. My social life has suffered due to care giving:

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

9. I get everything done I need to in a typical day:

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

10. I have trouble keeping my mind focused:

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

11. I am irritable or angry more that I used to be:

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

12. I feel like I have nowhere to turn for help:

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

What do you hope to get from having this voucher for respite? _____

_____

Caregiver signature: _____ **Date:** _____

ADL / IADL Checklist

Using a person's functioning level as it relates to Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) can help with determining the level of care assistance that person needs. Use this easy list to get a baseline of needs based on the actual activities it takes to maintain independence.

Activities of Daily Living (ADLs) are activities in which people engage on a day-to-day basis. These are everyday ***personal care*** activities that are fundamental to caring for oneself and maintaining independence.

Instrumental Activities of Daily Living (IADLs) are activities related to ***independent living*** and are valuable for evaluating persons with early-stage disease, both to assess the level of disease and to determine the person's ability to care for himself or herself.

Use the Activities of Daily Living and Instrumental Activities of Daily Living list below and check the level of function for the person as it relates to each activity.

Activities of Daily Living (ADL)

ADL Function	Independent	Needs help	Dependent	Cannot do
Bathing				
Dressing				
Grooming				
Mouth Care				
Toileting				
Transferring bed/chair				
Walking				
Climbing stairs				
Eating				

ADL / IADL Checklist

Instrumental Activities of Daily Living (IADL)

IADL Function	Independent	Needs help	Dependent	Cannot do
Shopping				
Cooking				
Managing medications				
Using the phone and looking up numbers				
Doing housework				
Doing Laundry				
Driving or using public transportation				
*Managing finances				

* Financial management should never be done by the same person who is providing care.

Recognizing a person's limitations is the first step in developing a care plan (or making a referral for care) to provide the appropriate type and level of assistance. Determining the type of ADL and IADL care that is needed also enables a clear idea whether or not staying at home with care is an option.

What Questions Could You Ask an Older Adult Regarding Their ADL's?

1. Can your loved one prepare and serve adequate meals independently, or do the need assistance obtaining ingredients and maintaining a healthy diet?
2. Are the capable of moderate domestic work, like regularly washing dishes?
3. Can your loved one managed their finances independently (including budgeting, writing checks, paying bills, visiting the bank), or do they need assistance with handling money?
4. When it comes to transportation, are the capable of getting around independently, or are they restricted to traveling with the assistance of others?
5. Are the prepared to operate and dial a phone to communicate with the world, or are they unable to dial, or only dial a handful of numbers?
6. How do their activities of daily living change if living alone and unsupervised?

CSP Agreement

Respite care provides temporary relief for a primary caregiver, enabling you to take a much-needed break from the demands of caregiving a sick, aging, disabled family member or a grandparent raising a grandchild. Our program is a 60-day program and available every 6 months.

Seeking support and maintaining your own health are key to managing your role as a caregiver, so it's not selfish to need time to yourself. Our program can help ease the burden of family caregiving and help to relieve stress, restore your energy, and promote balance in your life. It can also prevent you from becoming exhausted, isolated, or even burned out. Respite care can benefit the person you're caring for, too, providing them with variety, stimulation, and a welcome change of routine. Respite providers work 2 hours a day Monday – Friday or other agreed upon time that has been approved for no more than 10 hours a week/ 20 hours per pay period.

The following duties may or may not apply:

Providing ill, elderly, or disabled clients with assistance, companionship, and comfort.

Engaging clients in suitable activities, such as socializing, playing games, or reading out loud.

Assisting clients with mobility, personal hygiene, eating, and drinking.

Performing general household duties, such as cleaning, cooking, and shopping.

Maintaining a hygienic and safe environment.

Maintains confidentiality regarding client.

Providing a grandparent with the resources to have a much-needed break.

Our program at times may have available funding to assist with some extracurricular activities, school supplies, special activities for GRG and our lending closet can assist with adult hygiene products, blue pads, wipes, gloves, assistive devices etc. for elderly program participants who are not eligible for other programs. (limited availability)

The Respite Provider is responsible for keeping a record of the hours worked on a timesheet (must be legible). This timesheet/proof of service is to be submitted to our office 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 the Respite Provider will have to fill out a 1099 Form. At all times the safety of the client is top priority, any and all activities must be agreed upon between both parties.

By signing this agreement both parties agree to all terms stated in this application

Signature of Respite Provider: _____ Date _____

Signature of Caregiver/Care Receiver: _____ Date _____

CSP TIME SHEET

(DUE EVERY TWO WEEKS)

Pay Period____/____/____ To____/____/____

RESPITE/GRANDPARENT NAME:_____

DAY	DATE	START TIME	END TIME	TOTAL TIME	DUTIES PREFORMED	INITALS
SUNDAY						
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
DAY	**DATE**	**START TIME**	**END TIME**	**TOTAL TIME**	**DUTIES PREFORMED**	**INITALS**
SUNDAY						
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						

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

_____ _____

Respite Provider/Grandchild(ren) Date Caregiver/Grandparent Date

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

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

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ – ___ – ____

or

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); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 for Part II, later.

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.