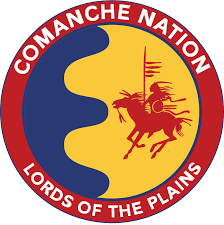
PG 1



COMANCHE NATION

ELDER CAREGIVER PROGRAM

APPLICATION

The Comanche Elder receiving service must be 62 years of age or older and in need of assistance

**or** a Comanche who is 100% disabled if under 62 years of age.

PG 2

**CAREGIVER INTAKE FORM**

**ELDER/CLIENT INFORMATION**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ County of Residence \_\_\_\_\_\_\_\_\_\_\_\_\_

Tribal Role # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where will the care of the Elder/Client take place?

Elder/Disabled Client’s Home \_\_\_\_\_ Caregiver’s Home \_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Source(s) of Income \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Income \_\_\_\_\_\_\_\_

Spouse/Friend/Realative living in home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number’s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PG 3

**Elder Care**

The Caregiver Program will have 3/6 months of assistance for Respite care for the Elder/Disabled Client. Eligibility will be for those in greatest need with two or more Activities of Daily Living (ADLs). After 3/6-month program there will be a break of one to two months, during this time new participants will be assisted. (Doing this will allow us to take care of more clients/elders)

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. We will need the disability letter to put in clients chart.

How old is the disabled individual and is he/she 100% disabled and in need of personal and basic care? Please explain and attach proof of 100% disability.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_

PG 4

**PHYSICIAN/PHARMACY INFORMATION**

Primary Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PG 5

**ELDER/CLIENT ASSESSMENT**

**Requires assistance with Activities of Daily Living (ADL) - need two to be eligible.** Check all that apply:

Eating \_\_\_\_\_\_\_\_\_\_\_ Dressing \_\_\_\_\_\_\_\_\_\_\_ Bathing \_\_\_\_\_\_\_\_\_\_\_\_

Transferring \_\_\_\_\_\_\_ Toileting \_\_\_\_\_\_\_\_\_\_ Incontinence \_\_\_\_\_\_\_

Requires supervising due to Alzheimer’s or Dementia \_\_\_\_\_\_\_

**Requires assistance with two instrumental IADLs(Instrumental Activities of Daily Living). Check all that apply:**

Preparing Meals: \_\_\_\_\_\_\_\_\_ Housework: \_\_\_\_\_\_\_\_\_

Laundry: \_\_\_\_\_\_\_\_\_ Prescription Medication \_\_\_\_\_\_\_\_

Shopping \_\_\_\_\_\_\_\_\_ Using Telephone: \_\_\_\_\_\_\_\_\_

**Chronic conditions that lead to disability:** Check all that apply

Heart Disease \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Diabetes \_\_\_\_\_

Pulmonary Disease \_\_\_\_\_ Stroke \_\_\_\_\_\_ Hearing loss \_\_\_\_\_\_\_

Vision loss \_\_\_\_\_ Orthopedic \_\_\_\_\_ Hypertension \_\_\_\_\_\_

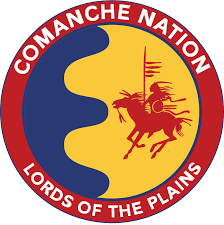
**Please check** if the Elder/Client receives the following: Hospice \_\_\_\_\_

Home Heath \_\_\_\_\_ DHS Services \_\_\_\_\_ CHR Services \_\_\_\_\_

Meals from Comanche Nation Elder Center \_\_\_\_\_

**Does the Elder need assistance with the following items**:

Wheelchair \_\_\_ Walker \_\_\_ Cane \_\_\_\_ Hearing Aid \_\_\_\_ Other \_\_\_\_\_

 **CAREGIVER CONTRACTER APPLICATION** PG 6

(this is for person who will be caring for elder and being paid for it)

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 any day of the week? 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 \_\_\_

Are interested in attending a monthly support group? Yes\_\_\_ No \_\_\_

Caregivers may be requested to take a drug test at anytime.

Name of Elder you will be providing care for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Caregiver \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

PG 7

**RESPITE CONTRACT SERVICE**

**AGREEMENT AND RESPONSIBILITIES**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to the terms of this agreement and enter into agreement

(Print Caregiver’s Name)

to provide contractual service with the Comanche Nation Caregiver Program. I have the responsibility to provide Respite Care for 3/6 months only with payment for up to 10 hours per week at $12 an hour. 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.

**May at some point be drug tested** during my time as a Caregiver for the Elder or disabled on this Program. (The CBC has adopted a zero-tolerance policy on drugs, alcohol and other prohibited items.)

**Independent Contractor**. This Agreement shall not render the Contractor an employee, partner, agent of, or joint venture with the Nation for any purpose. The Contractor is and will remain an independent contractor in this relationship to the Nation. The Nation shall not be responsible for withholding taxes with respect to the Contractor’s compensation hereunder. The Contractor shall have no claim against the Nation hereunder or otherwise for vacation pay, sick leave, retirement benefits, social security, worker’s compensation, health or disability benefits and unemployment insurance benefits.

**No changes** or modifications will be made to this agreement.

**RESPITE CONTRACT SERVICE DATA**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

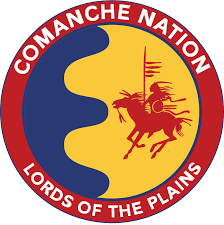
Respite/Caregiver Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADMINISTRATIVE APPROVAL**

Date to start Respite Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Respite Care is discontinued \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PG 8

COMANCHE NATION CAREGIVER PROGRAM

P.O. BOX 908, LAWTON 73502

Phone 580-492-1146 FAX 580-492-5297

Elder/Client 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. Since we will only be able to serve those most in need, your assistance is very much needed and appreciated.

What is 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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications and reasons prescribed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special needs of the individual making our service necessary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_

Name of Physician (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for your assistance**.