

**OTOE-MISSOURIA TRIBE
NATIVE AMERICAN CAREGIVER SUPPORT PROGRAM
CAREGIVER APPLICATION**

FAMILY CAREGIVER INFORMATION

Name: _____ M F **Date:** _____

Tribe: _____ **CDIB:** Yes _____ No _____

Birth Date: _____ **SSN:** _____

Address: _____

City/State/Zip _____

Phone Number: _____ **Work/Msg#:** _____

Number of household members: _____ children _____ adults

What is your relation to the elder? _____

.....
Notes: Briefly describe your involvement as a family caregiver for your elder/child.

Assessment Tool

Elder/Child is a ____ of the Caregiver

1. Spouse
2. Child
3. Grandchild
4. Parent
5. Other

Elder/Child lives:

1. In their home
2. In Caregiver's Home
3. Other residential are
4. Nursing home

Number of people who live is Elder/Child's household _____

Please circle:

Diagnosis of Recipient:

1. Limited Mobility
2. Stroke
3. Alzheimer's/Dementia
4. Depressed/Anxiety
5. Mental Illness
6. Cancer
7. Diabetes
8. CHF
9. Hypertension
10. Other: _____

Recipient currently has the following services in place:

1. Home Health
2. Support Group
3. Transportation
4. Housekeeping/Chore
5. Respite
6. Nutrition
7. Other, please specify _____

Services Needed:

1. Home Health
2. Support Group
3. Transportation
4. Housekeeping/Chore
5. Respite
6. Nutrition
7. Other, please specify _____

Personal Care Needed:

1. Bathing
2. Dressing
3. Eating
4. Toileting
5. Transferring

Trainings Needed:

1. Stress Management/burn-out
2. Care giving Tips/Strategies
3. Caregivers in the Workplace
4. Safety in the Home
5. Medication Management

Care giving Request:

1. Information/packet
2. Counseling/Phone
3. Referral
4. Support Group
5. Follow up

Other Information:

CAREGIVER ELDER INFORMATION

Name: _____ M F

Address: _____

Finding Address (if different) _____

City/State/Zip _____

Phone Number: _____

Tribe: _____ Birth Date: _____ SSN: _____

Elder has: Medicare _____ Medicaid _____ Private Insurance _____

Number of people who live in Elder's household _____

Please list elder's illness, disease, or disabilities:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please check, if elder receives the following:

1. Hospice _____ 2. Home Health _____ 3. DHS Advantage Program _____
4. Nutrition Meals from Creek Nation Elderly Nutrition Center _____ 5. Transportation by CHR _____

Does your elder use any assistive devices such as the following:

Wheelchair _____ Walker _____ Cane _____ Hearing Aid _____

Other (Please list) _____

Does your elder need assistance with personal needs? (Please circle)

- 1. Bathing
- 2. Dressing
- 3. Eating
- 4. Toileting
- 5. Walking or wheelchair
- 6. All

Caregiver Application

SIGNATURE PAGE

Confidentiality and Disclosure of Information:

No information about a participant or obtained from a participant by this program will be disclosed in a form that identifies that person without the informed consent of the person, or of his or her legal representative, unless the disclosure is required by court order or for program monitoring by federal funding agencies or Tribal Council requirements.

No information will be disclosed that is exempt from disclosure by a federal agency under the Federal Freedom of Information Act, 5U.S.C.502

Acknowledgement:

_____ Date: _____
Applicant – Family Caregiver Signature

Verification of Information

I have answered all questions to the best of my ability and knowledge, and authorize Otoe-Missouri Division of Health Administration, N.A. Caregiver Support Program to communicate with the above individuals and/or agencies in processing my application. THIS APPLICATION IS NOT A BINDING CONTRACT AND DOES NOT BIND EITHER PARTY. The above information is true and correct and I realize falsification is automatic reason for this application to be disapproved and the applicant shall be considered ineligible for the program. Punishable by Section 1001 of Title 18 of the U.S Code which makes it a criminal offense to make willful, false statements for misrepresentation of any material fact involving the use or obtaining of federal funds.

Applicant- Family Caregiver Signature

Date

LIABILITY / MEDICAL RELEASE

I, _____, release the Otoe Tribe from any or all liability in the event of any accidents, which may occur while in transit. I also understand that all liability is waived to any Otoe Tribal employee should an accident occur while I am traveling in the employees personal or an Otoe Tribal vehicle, or while the employee is my own personal vehicle. The release will provide coverage for all transits.

Name of Traveler _____

Primary Physician _____

Address _____

Phone # _____

Person to contact in event of emergency _____

Any Medication Allergies _____

Any Medical Conditions _____

Heart Condition _____

Diabetic _____

Signature of Traveler

Caregiver Program Respite Service

ELIGIBILITY REQUIREMENTS

- Applicants must be age 18 or over and meet the definition of a family caregiver. “Anyone who is currently providing care and support to an elder (55 or older), who is ill or frail and cannot manage independently without assistance.”
- Elder must be age 55 or older and unable to perform at least two activities of daily living.
- Applicant and elder must reside within the Otoe-Missouri service area.
- Either the Family Caregiver or the Elder must be a member of a federally recognized tribe.

Priority and Preference Guidelines

Applicants whose elders are under the following category will receive priority:

1. Receiving Hospice
2. Receiving Home Health
3. Have had recent surgery
4. Is diagnosed with Alzheimer’s or other cognitive disease
5. Those over 80
6. Those over 70
7. Those over 55

Preference will be determined based on program funding and if:

1. Both Family Caregiver and Elder are Otoe-Missouria citizens
 2. Both Family Caregiver and Elder are members of a federally recognized tribe
 3. Either the Family Caregiver or the Elder are members of a federally recognized tribe
- Original application must be returned. No fax copy will be accepted.
 - Applications will be processed according to priority and preference guidelines
 - Once approved, applicants must attend a one hour training session and a one hour introductory support group session, before funds are released.

