



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.

1001 S.E. 36th St. Lawton, OK 73501
Caregivers@comanchenation.com
Caregiver Phone: (580)360-5400
Phone: (580)360-0771

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/Relative living in
home: _____

Insurance: _____

Emergency Contact Person _____

Phone number's: _____

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 _____

PHYSICIAN/PHARMACY INFORMATION

Primary Physician _____

Address _____

Telephone # _____

Preferred Hospital _____

Pharmacy _____

Telephone # _____

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 Health _____ 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

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(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 _____

**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 _____



COMANCHE NATION CAREGIVER
PROGRAM
P.O. BOX 908, LAWTON 73502
Phone (580)-360-5400

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.
