

**APACHE TRIBE OF OKLAHOMA
CAREGIVER SUPPORT PROGRAM
POLICY AND PROCEDURES**

POLICY:

It will be the policy of the Apache Tribe Native American Caregiver Support Program to offer support services to all eligible Native American Caregivers residing in the tribal service area as well as respite care when program funds are available.

PROCEDURES:

Eligibility

1. Priority; Older individual with the greatest social and economic need and older individuals providing care and support to persons with mental retardation and related developmental disabilities.
2. Participants must reside within the Apache Tribal Service Area.
3. Participants must be an enrolled member of a federally recognized tribe.
4. Caregivers are Native Americans who are 18 years and older, who provide care and support services for an individual who, for reason of illness or frailty, cannot manage independently with assistance.
5. Care Receiver must be a Native American elder of the age of 60 and needs assistance with (2) of the criteria of Activities of Daily Living (ADL's) that include eating, dressing, bathing, transferring, toileting, walking, shopping, doing laundry, managing money, taking medication, and require supervision due to Alzheimer's or other Dementia.
6. Grandparents (60) years or older, who are primary caregivers residing with a child (under 18 years of age), and have legal relationship with the child or are raising the children.
7. The Respite Provider must be age 18 or older.
8. Respite Providers/Caregivers are not considered employees of the Apache Tribe of Oklahoma, but are temporary program participants receiving services for a one-time basis.
9. Caregivers/Respite Providers must attend one training session during each 3 month funding period. If Caregiver/Respite Provider fails to attend, the Caregiver/Respite Provider will be terminated from the program.
10. Family members who show proof that Caregivers/Respite Providers are not taking proper care of the Care receiver will be immediately terminated.

The Tribal Caregiver Support Program provides:

1. Respite Assistance
2. Opportunity for the Caregiver to access assistance services.
3. Caregiver Training
4. Caregiver Support Groups
5. Resource assistance information will be collected and provided to the Tribal Caregiver clients who are in the Tribal Programs service area.
6. Contracting for services from local health care agencies for: Caregiver training, forming caregiver support groups, and basic caregiver coping skills.

The Tribal Caregiver Support Program does not provide:

1. Background checks on Respite Providers; Caregiver is responsible for background checks.
2. Mediation for family conflicts. Tribal Caregiver Support Program is to remain impartial.

**Apache Tribe of Oklahoma
CAREGIVER PROGRAM APPLICATION**

RESPITE CAREGIVER INFORMATION

Name (Mr., Mrs., Ms.): _____

Date of Birth: _____ Social Security No.: _____ Age: _____

CDIB #: _____ Tribal Affiliation: _____

Address: _____
City State Zip Code

Phone Number(s): Home: _____ Work: _____ Cell: _____

Are you receiving any other assistance? No Yes If yes, from whom? (check below)

Home Health Hospice Private Duty Other _____

YOUR RELATIONSHIP TO CARE RECEIVER:

Spouse Daughter/Son Grandparent Other _____

CARE RECEIVER INFORMATION

Name (Mr., Mrs., Ms.): _____

Date of Birth: _____ Social Security No.: _____ Age: _____

CDIB #: _____ Tribal Affiliation: _____

Address: _____
City State Zip Code

Phone Number(s): Home: _____ Work: _____ Cell: _____

Need assistance with peronal care (check all that apply):

Bathing Eating Walking Dressing Toileting Transferring Medication

Needing supervision due to Alzheimer's/Dementia Other _____

Caregiver Signature: _____ Date: _____

Caregiver Coordinator: _____ Date: _____

**RESPITE CONTRACT SERVICE
AGREEMENT AND RESPONSIBILITIES**

I, _____, the applying Respite Aide, agree to the terms of this agreement and enter into agreement to provide service with _____, a Family Caregiver.

I understand that the Family Caregiver with the approval of Apache Tribe of Oklahoma Caregivers Program may from time to time renew this agreement.

I have the responsibility to provide Respite Care for up to 5 hours per week, and agree to the rate of \$ 6.60 per hour. (Prior approval from the Apache Tribe Caregivers Program)

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

- To assist the Family Caregiver by keeping a timesheet that accurately verifies the number of hours that I provided respite support.
- To submit the timesheet, to the Apache Tribe Caregiver Support Program, with a signature of the Primary Family Caregiver verifying approval for payment.
- To assist the Family Caregiver to make application with other agencies for long-term Respite Service.
- That no change or modification be made to this agreement.

Please Print

RESPITE AIDE DATA

Name (Mr., Mrs., Ms.): _____ Social Security No.: _____

Address: _____
City State Zip Code

Phone Number(s): Home: _____ Work: _____ Cell: _____

Signature: _____ Date: _____

FAMILY CAREGIVER DATA

Name (Mr., Mrs., Ms.): _____ Social Security No.: _____

Address: _____
City State Zip Code

Phone Number(s): Home: _____ Work: _____ Cell: _____

Signature: _____ Date: _____

ADMINISTRATIVE APPROVAL

Approval: _____ Date: _____

Updated 12-23-15 Caregiver Coordinator

EMERGENCY CONTACT INFORMATION FOR CARE RECEIVER

Care Receiver's Name: _____
First name Middle name Last name Nickname

Gender: Male Female Date of Birth: _____ Place of Birth: _____
(country/region)

Home address (Physical): _____ District/County: _____

Medical Information

Name of Physician: _____

Address: _____ Phone number: _____

Care Receiver's Blood type: _____ Medical conditions: _____

Allergies: _____ Current medications: _____

Next of Kin

Name: _____ Relationship: _____
First name Middle Initial Last name

Address: _____
City State Zip Code

Phone Number(s): Home: _____ Work: _____ Cell: _____

AUTHORIZATION TO RELEASE INFORMATION

**APACHE TRIBE OF OKLAHOMA
CAREGIVER SUPPORT PROGRAM
601 E. COLORADO
P.O. BOX 1330
ANADARKO, OK 73005**

I hereby authorize _____ to release information contained in medical records to:
Apache Tribe of Oklahoma Caregiver Support Program, pertaining to the diagnosis, treatment, and prognosis of:

Patient's Name

Date

To the following:

Agency/Individual Name: _____

Signature and Date: _____

Agency/Individual Name: _____

Signature and Date: _____

Patient's Physician: _____

Hospital _____ Phone # _____

Address: _____

I understand that my authorization will remain effective from the date of my signature until I no longer receive services through the Apache Tribe of Oklahoma Caregiver Support Program, and that the information will be handled confidentially and in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time in writing.

I have read and understand the nature of this release.

A copy of this authorization may be accepted as an original.

Signature of Patient/Patient's Legal Representative

Date

Updated 12-23-15
Caregiver Coordinator

This page must be signed and returned before future payments will be released.

**Apache Tribe of Oklahoma
Caregiver Support Program
510 E. Colorado
P.O. Box 1330
Anadarko, OK 73005**

Ph.: 405-247-6330

Fax: 405-247-7695

Payment Receipt

Date: _____

Check Number: _____

Paid to _____ **\$** _____

_____ **Dollars**

For _____

Participant Signature

Caregiver/ AOA Signature

Caregiver Support Program

Checklist

- Policy and Procedures (Copy for Respite Aide)
- Apache Tribe Caregiver Application
- Respite Contract Service Agreement/Responsibilities
- Care Receiver Emergency Contact Information
- Authorization to Release Information
- Respite Pay Record/Unit of Service
- Respite Pay Rate/Pay Schedule (Copy for Respite Aide)
- Respite Timesheets (Copies for Respite Aide)

2016 Respite Caregiver Pay Schedule

Respite Caregivers will begin the program starting at the beginning of a Quarter, and will receive six (6) vouchers within a three (3) to four (4) month period. The maximum allowed will be five (5) hours per week at \$6.60/hr. Not to exceed ten (10) hours within a two (2) week period. Any overages will be paid out on the last voucher. Total amount received will be \$400.00.

Pay Period #	Pay Period Dates	Timesheets Due
4 th QTR	01/04/16 – 01/17/16	1/18/2016
	01/18/16 – 01/31/16	2/1/2016
	02/01/16 – 02/14/16	2/15/2016
	02/15/16 – 02/28/16	2/29/2016
	02/29/16 – 03/13/16	3/14/2016
1 st QTR	03/14/16 – 03/27/16	3/28/2016
	03/28/16 – 04/10/16	4/11/2016
	04/11/16 – 04/24/16	4/25/2016
	04/25/16 – 05/08/16	5/9/2016
	05/09/16 – 05/22/16	5/23/2016
	05/23/16 – 06/05/16	6/6/2016
2 nd QTR	06/06/16 – 06/19/16	6/20/2016
	06/20/16 – 07/03/16	7/4/2016
	07/04/16 – 07/17/16	7/18/2016
	07/18/16 – 07/31/16	8/1/2016
	08/01/16 – 08/14/16	8/15/2016
4 th QTR	08/15/16 – 08/28/16	8/29/2016
	08/29/16 – 09/11/16	9/12/2016
	09/12/16 – 09/25/16	9/26/2016
	09/26/16 – 10/09/16	10/10/2016
	10/10/16 – 10/23/16	10/24/2016
	10/24/16 – 11/06/16	11/7/2016
	11/07/16 – 11/20/16	11/21/2016
	11/21/16 – 12/04/16	12/5/2016
	12/05/16 – 12/18/16	12/19/2016