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.
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 personal 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: ____________

Updated 12-23-15
Caregiver Coordinator
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 _____ hours per week, and agree to the rate of $__________ 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: __________________________

Updated 12-23-15
Caregiver Coordinator
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
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)*
<table>
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<tr>
<th>DATE:</th>
<th>REMARKS:</th>
<th>STAFF INITIALS</th>
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## RESPITE PAY RECORD AND UNIT OF SERVICE FORM

### CLIENT INFORMATION

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<tr>
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<th>AGE</th>
<th>RELATIONSHIP</th>
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### RESPITE PAYMENT RECORD

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<th>Hourly Rate of Pay</th>
<th>Hours Provided Care</th>
<th>Voucher No. #</th>
<th>Starting Amount</th>
<th>Amount Claimed</th>
<th>Remaining Amount</th>
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### UNIT OF SERVICE

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<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>Telephone</th>
<th>Services **</th>
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A. Information to caregivers about services
B. Assistance to caregivers in gaining access to the services (individual one-on-one contact linking to services available).
C. Individual counseling, organization of support groups, and caregiver training to caregivers to assist the caregivers in making decisions & solving problems relating to their care giving roles.
D. Respite care to enable caregivers to be temporarily relieved from their care giving responsibilities*
E. Supplemental services, on limited basis, to complement the care provided by caregivers*

* ADL (needing assistance with at least two personal care)
** Services identifying chronic illness or disabling conditions

Revised 12-23-15
Caregiver Coordinator
# 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.

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