APPLICATION FOR RESPITE SERVICE

There are three parts to the program; Caregiver, Elder and Respite Worker.

1. **Caregiver – person who cares for the elder.**

2. **Elder/Disabled Adult/Child**

3. **Respite Worker – The person who gets paid to help/ relieve the caregiver.**

Please send completed application to:

Caregiver Program
PO Box 580
Okmulgee, OK 74447

Elder/Disabled Adult/Child **MUST already have a Caregiver.**

It is the Caregiver's responsibility to find a Respite Worker. In the event one cannot be found, a Caregiver Advocate may help the Caregiver find one.

THIS APPLICATION IS:

_____Approved _____Disapproved _____Pending

REASON: _____

REVIEWED BY: _____

DATE: _____

FOR OFFICE USE ONLY:

Requisition #: _____

PO #: _____

NATIVE AMERICAN CAREGIVER SUPPORT PROGRAM

Notice:

Please complete all questions on application. Any misrepresentation of information related to eligibility, family composition or medical diagnosis will be grounds for disapproval of this application and possible criminal charges.

Applications will be limited to **ONE** contract per household per funding year.

The Caregiver Program may refuse service to clients (Caregivers, Respite Workers, Elders, Disabled Adults, Children) who are verbally, physically, or mentally abusive to Caregivers, Respite Workers, Elders, Disabled Adults, Children, or program staff. Every effort should be made to safeguard the safety of all staff, caregivers, respite workers, elders, disabled adults and children, including the physical removal of abusive clients from the Caregiver Program office, or clients homes, by Lighthorse Police or local law enforcement.

Applications will be processed according to order of receipt.
Applications will be rated according to priority and preference.
Applications will be considered complete after a home visit is conducted.

Services Available:

- Information
- Assistance
- Counseling, Training, Support Group
- Respite
- Supplemental Services
- Lending Closet

RESPITE CARE

Respite care provides the caregiver with "time off" or a "break" from their care giving duties. The caregiver selects his/her own respite worker. The rate of pay is $10.00/hr. The number of hours is determined by the caregiver, which is based on needs for the elder and child.

Respite service funds are limited to $1200. **Applications will be limited to one contract per household during a fiscal year. (April 1 thru March 31/Grant or October 1 thru September 30/Tribal). The funds will be distributed in $300 increments and four fiscal quarters.**

NATIVE AMERICAN CAREGIVER SUPPORT PROGRAM

Caregiver Program Respite Services

ELIGIBILITY REQUIREMENTS

* Elder, Disabled Adult, Child, or Caregiver must be enrolled in a federally recognized tribe within MCN jurisdiction.
* Elder must be unable to perform at least two activities of daily living.
* Respite Worker 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."
* Respite Worker must pass criminal investigation background check.
* Copy of tribal card

Priority and Preference Guidelines:

1. **Caregivers with the greatest social and economic need**
2. **Caregivers providing care to individuals with severe disabilities**
3. **Caregivers providing care for individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction**
4. **Native American grandparents or relatives over the age of 55, who reside with and provide primary care for a child 18 years or younger.**

Training Requirements:

One hour, every year, of training is mandatory for the respite worker and caregiver.

Native American Caregiver Support Program

Caregiver Information

Date: _____

Caregiver Name:_____M_____F____

DOB: _____Tribe: _____Last 4 #'s of SS: _____

Address: _____

City: _____County: _____Zip: _____

Phone#_____Email:_____

Relationship to elder/disabled adult/child:_____

Reason for requesting services: _____

Other information you would like to include:

_____

_____

_____

Native American Caregiver Support Program

Signature Page

Confidentiality and Disclosure of Information:

No information about a participant will be disclosed by this program without the informed consent of the participant or his/her legal representative, unless the disclosure is required by court order or for program monitoring by Federal funding agencies.

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

Verification of Information

I have answered all questions to the best of my ability and knowledge, and authorize the Native American 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 caregiver shall be considered ineligible for the program. Punishable by Section1001 of Title 18 of the U.S. Code which makes it a criminal offense to make willful, false statements for misrepresentations of any material fact involving the use or obtaining of Federal Funds

_____

Caregiver Signature **Date**

Native American Caregiver Support Program

CAREGIVER RESPONSIBILITES

1. **To participate in a scheduled caregiver training session.**
2. **To choose a Respite Worker.**
   Caregivers may choose a family member, neighbor or friend. Respite Workers **may not** be hired if he or she lives with the elder, child or the caregiver.
3. **To train your respite worker.**
   Should your elder or child require special assistance, it is your responsibility to inform your worker and provide training if necessary. If you would like your worker to participate in our caregiver training session, please feel free to call and set up an appointment.
4. **To provide a schedule of work hours per contract agreement.**
5. **To ensure your worker fully understands his or her duties and the time and hours to be worked.**
6. **To approve and sign your worker's invoice.**
7. **Caregiver will be responsible for all cost above the maximum amount authorized.** The Caregiver Support Program is not responsible for those invoiced hours which exceed the amount authorized; as shown on the Respite Contract Service Agreement.
8. **To hire a different Respite Worker, you must put your request in writing.**
   In the event, you need to change your respite worker, please request this in writing with a brief reason for this change. You will then receive new Respite Worker forms. The new worker will work the remaining amount of hours left from your original contract.
9. **Caregivers using respite funds are subject to random audits to ensure that funds are used for respite service only; respite service DOES NOT include heavy household chores.**

Acknowledgement:

I have read and understand the above Caregiver Responsibilities and I agree to act in accordance with the above responsibilities.

_____

CAREGIVER **DATE**

Native American Caregiver Support Program

ELDER/DISABLED ADULT INFORMATION

Name: _____M____F_____

Tribe:_____DOB: _____SSN: _____

Address: _____

City: _____County: _____ Zip: _____

Phone#_____Msg#_____

Does elder live: **(please circle) 1**. In their own home **2.** With Caregiver **3**. Other

Number of people living with elder: _____

Elder: _____Medicare _____Medicaid _____Private Insurance

Disabled Adult: _____Medicare _____Medicaid _____ Private Insurance

Diagnosis of Elder/Disabled Adult:

☐ **Limited Mobility** ☐ **Stroke** ☐ **Alzheimer's** ☐ **Depression/ Anxiety** ☐ **Cancer** ☐ **Diabetes**

☐ **Dialysis** ☐ **Other:** _____

Does the Elder/Disabled Adult receive any of the following?

☐ **Hospice/ Home Health** ☐ **Respite** ☐ **Meals** ☐ **Housekeeping** ☐ **Nutrition** ☐ **Transportation**

☐ **Other:**_____

Does the Elder/Disabled Adult use any assistive devices such as the following?

☐ **Wheelchair** ☐ **Walker/Cane** ☐ **Hearing Aid** ☐ **Other:**_____

Identify what the Elder/Disabled Adult needs assistance with:

☐ **Cooking** ☐ **Houskeeping** ☐ **Shopping** ☐ **Transportation** ☐ **Other:**_____

Native American Caregiver Support Program

RESPITE WORKER APPLICATION

All information submitted on this application is subject to verification. False or misleading responses may result in disqualification for participation.

Personal Information

Name: _____
Last First Middle

Address: _____ Phone# _____

City: _____ County: _____ Zip: _____

SS# _____ DOB: _____ Tribe: _____

Relationship to caregiver: _____ Relationship to elder/child: _____

Driver's License #: _____ State of Issue: _____

Have you ever been convicted of a felony? __Yes __No
If yes, please indicate the crime(s), jurisdiction of adjudication, and date(s) of conviction

_____

Are you currently charged with a crime other than a traffic violation? __Yes __No
If yes, please indicate the crime, jurisdiction of adjudication, and current status of the case

_____

****Please note, a failure to disclose criminal convictions may result in the application being withdrawn from consideration or disqualification for participation.**

Email Address: _____

Acknowledgment & Release of Liability

I acknowledge that consideration for participation is contingent upon the results of a background investigation. Therefore, I hereby authorize the Muscogee (Creek) Nation to investigate the truthfulness of all statements made on this application; contact any persons who can verify information which was provided, discuss the results of any investigation with other employees of the MCN involved in the program; check my driving record, and my criminal record. I also give my consent for all contacted persons to provide information concerning this application. I release each such person from liability for providing information to the Muscogee (Creek) Nation.
I certify that the information contained in this application is correct to the best of my knowledge, and understand that falsification of this application in any detail is grounds for disqualification from further consideration and dismissal from this program. By my signature below, I confirm that I have read and understand the information on this form.

_____ _____
Signature **Date**

Native American Caregiver Support Program

RESPITE WORKER RESPONSIBILITIES

1. **To provide respite service to the caregiver.**
   The time and dates of work will be scheduled by the caregiver. If you are unable to fulfill this responsibility, please notify the caregiver as soon as possible.
   The scope of work is also something agreed upon by you and your caregiver.
   Please be sure you understand and agree with what responsibilities you are asked to do before signing the CONTRACT AGREEMENT.
2. **To participate in any training or informational sessions.**
   Training sessions will be a requirement for all respite workers and should be completed within the first 90 days of the contract period. Not attending a training session can affect your ability to receive supplemental supplies.
3. **To discuss with your caregiver any problems or concerns.**
   Please report to your caregiver any problems or concerns which may arise during your service. **Your caregiver is your supervisor.**
4. **To provide a complete and accurate Respite Service Invoice.**
   Please ensure your invoice is completely filled out, including your name and your address this is where your check will be mailed. Also, make sure your caregiver signs and dates each invoice.
5. **To ensure your invoice is mailed or delivered to our office.**
   It is your responsibility to submit your invoice in our office for processing this will ensure payment the following week.
6. **To complete and submit the I.R.S. W-9 Form.**
   According to federal **I.R.S.** standards, the respite worker is considered an independent Contractor and will receive a 1099 form at tax time.

7. The Respite Worker is not an employee of the Muscogee (Creek) Nation and nothing in this Application shall be deemed to create an employment or agency relationship, partnership, joint venture, or other special relationship between the parties. Respite Worker shall not have any right or authority to assume or create any obligations binding upon the Nation, in any respect whatsoever, or to represent to any person that Worker has any such right or authority. Worker shall not be entitled to employment benefits of any kind from the Nation and Worker expressly waives any and all claims thereto. Worker shall be solely responsible for the payment of all taxes and other withholdings in respect of the amounts paid by the Nation under this Application and hereby agrees to pay such amounts in accordance with applicable law (including but not limited to federal social security tax, as well as federal and state unemployment taxes).

Acknowledgement:

I have read and understand the above Caregiver Responsibilities and I agree to act in accordance with the above responsibilities.

_____

Respite Worker **Date**

Disclaimer: This Notice – Background Investigation document is intended for instructional purposes only and is not intended as Legal advice. We recommend you consult with an attorney to review this document and the corresponding state notices to ensure your compliance with the applicable state laws related in background screening and consumer notes and disclosures.

NOTICE – BACKGROUND INVESTIGATION

In connection with your Respite Worker Application with [Muscogee Creek Nation] (the "Company"), notice is hereby given that a consumer report and or investigative consumer report may be obtained from a consumer reporting agency for employment purposes. These reports may contain information about your character, general reputation, personal characteristics and mode of living, whichever are applicable. They may involve personal interviews with sources such as your neighbors, friends or associates. The reports may also contain information about you relating to your criminal history, credit history, driving and/or motor vehicle records, education or employment history, or other background checks.

You have the right, upon written request made within reasonable time after the receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report prepared by contacting the Company and Shield Screening, 6810 East 121st South, Bixby, OK 7400; Phone: 1-800-260-3738. For information about Shield Screening's privacy practices, see www.shieldscreening.com. The scope of this notice and below authorization is not limited to the present and may continue throughout the course of your application period.

ACKNOWLEDGEMENT AND AUTHORIZATION

By signing below, I hereby authorize the obtaining of consumer reports and/or investigative consumer reports by the Company at any time after receipt of this authorization and throughout the course of my application period, if applicable.

Signature: _____ **Date:** _____

Print Name: _____ **SSN:** _____

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▸ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☑ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▸ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▸

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions. Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ – ___ – ____

or

Employer identification number

__ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▸ **Date** ▸

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

Native American Caregiver Support Program

RESPITE CONTRACT SERVICE AGREEMENT AND RESPONSIBILITIES

I, _____, **(respite worker)** agree to the terms of this contract and enter into an agreement to provide contractual service with_____, **caregiver.**

I agree to provide Respite Care, upon the approval date of this contract; at the rate of **$10.00** per hour.

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

1. I will invoice the Caregiver Program of the work hours, rate and total amount due.
2. I will ensure the invoice is signed by the Caregiver.
3. I will submit a W-9 IRS Form with the initial agreement.
4. I acknowledge that **NO** change or modifications will be made to this agreement.
5. **I acknowledge this contract will not exceed the allocated amount of $ 300.00 per funding period.**
6. **I acknowledge certain information revealed from the respite worker background check may be disclosed to determine eligibility for program participation.**

I understand that from time to time the Native American Caregiver Support Program (NACSP) may review the terms of my service. I also understand that this contract may, at any time, be terminated by the Caregiver or NACSP.

RESPITE CONTRACT WORKER

Name: _____SS#: _____

Address: _____ Phone: _____

Signature: _____ Date: _____

CAREGIVER

Name: _____ SS#_____

Address: _____ Phone: _____

Signature: _____ Date: _____

NASCP APPROVAL

_____ *Date:* _____

Agreement#: _____ Funding Period Begins: _____

Transportation Liability Waiver

The Native American Caregiver Support Program does not verify driver license, proper insurance or registration for respite workers participating in the program.

By signing below, I acknowledge that driving is an inherently risky activity that could result in severe injury or death. I acknowledge that I am responsible for my driver license and automobile insurance, during anytime that my vehicle is in use, while providing respite services to the caregiver.

I agree that the Native American Caregiver Support Program, the Muscogee (Creek) Nation, or any employees of those entities shall not be held liable in the event of any accident causing damage to vehicles, other property damage, or personal injury to anyone involved in an accident.

Printed Name/Respite Worker: _____

Signature: _____

Insurance Carrier: _____

Policy Number/Expiration Date: _____

Driver License #: _____

Caregiver Signature: _____

Date: _____

This Waiver will be valid for all transportation occurring as of and after the date below. This Waiver is valid April 1, 20__ through March 31, 20__ or October 1, 20__ through September 30, 20__ when approval is granted for services.