Choctaw Nation Health Services Authority
Healthy Aging

Grandparents Raising Grandchildren Respite Program Application

- Pays for respite to relieve informal family caregivers age 55+ for a child living in their home 18 years or younger
- Caregiver or child must have a CDIB card
- Must reside within the Choctaw Nation service area
- Respite care provider cannot be living in the home but can be a family member or friend who is at least 18 years old. Funds may be used for boys & girls club or summer camps.
- Parent cannot live in the home
- $300 max over a 3 month period
- Supplemental assistance may be available for an emergency
- Please submit all documents and allow up to 30 days to receive a check

Caregiver Signature: __________________________________________

Respite Signature: __________________________________________

Choctaw Nation Division of Tribal Services
Living out the Chahta Spirit  FAITH • FAMILY • CULTURE
Title VI Application / GRG Intake

Child(ren) Information
Name: ___________________________ County of Residence: ___________________
Address: ___________________________ DOB: ___________________________
City/State: ___________________________ CDIB/Tribe: ___________________________
Name: ___________________ DOB: ______ Name: ___________________ DOB: ______

Does the child(ren) qualify for Medicaid or Daycare Assistance?   □ Yes   □ No
If unsure, would you like us to assist you in applying?   □ Yes   □ No
Does a parent live in the home?   □ Yes   □ No
Do you feel the child would benefit from counseling?   □ Yes   □ No
Do you feel you would benefit from counseling?   □ Yes   □ No

Caregiver Information
Name: ___________________________ County of Residence: ___________________
Address: ___________________________ SSN: ___________________________
City/State: ___________________________ DOB: ___________________________
Phone #: ___________________________ CDIB/Tribe: ___________________________

Who lives in the home: ___________________________

Assessment of Caregiver
Requires assistance with Activities of Daily Living (ADL): (check all that apply)
☐ Eating   ☐ Dressing   ☐ Bathing
☐ Toileting   ☐ Incontinence   ☐ Transferring

Requires assistance with instrumental ADL: (check all that apply)
☐ Preparing Meals   ☐ Doing Housework   ☐ Doing Laundry
☐ Taking Prescriptions   ☐ Distance Walking   ☐ Doing Shopping
☐ Walker Required

Requires supervision due to Alzheimer’s or other dementia?   □ Yes   □ No
(check all that apply)
Chronic conditions leading to disability: ☐ Heart Disease, ☐ Stroke, ☐ Diabetes, ☐ Pulmonary Disease
Conditions affecting functioning ability: ☐ Arthritis, ☐ Osteoporosis, ☐ Vision Loss, ☐ Hearing Loss
Orthopedic impairment: ☐ Hypertension, ☐ Standing, ☐ Walking

Care Recipient Signature: ___________________________ Date: ________________
Assessment Completed by: ___________________________ Date: ________________
Respite Contract Service
Grandparents Raising Grandchildren
Agreement and Responsibilities

I, __________________________ (respite), agree to the terms of this agreement and enter into agreement to provide contractual service with ______________________ the Caregiver. I understand that the Family Caregiver with the approval of the Choctaw Nation of Oklahoma Caregivers Program may from time to time renew this agreement.

I have the responsibility to provide Respite Care for ________ hours and agree to the rate of $ ________. (Prior approval from the Choctaw Nation Caregiver Program)

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

• To assist the Family Caregiver by invoicing the Choctaw Nation that includes hours, rate, and total amount due
• To submit the invoice with a signature of the Family Caregiver verifying and approving for payment
• Submit a W-9 IRS for with the initial agreement
• That no change or modification be made to this agreement
• I do understand this is a temporary grant program

*PLEASE ALLOW 15-20 BUSINESS DAYS TO RECEIVE CHECK

Respite Contract Service Information

| Name: __________________________ | SSN: __________________________ |
| Address: ________________________ | DOB: ________________________ |
| City/State: ______________________ | Date: ________________________ |
| Signature: ______________________ | Date: ________________________ |

Family Caregiver Data

| Name: __________________________ | SSN: __________________________ |
| Address: ________________________ | DOB: ________________________ |
| City/State: ______________________ | Date: ________________________ |
| Signature: ______________________ | Date: ________________________ |

| Approval: ______________________ | Date: ______________________ |

Choctaw Nation Division of Tribal Services
Name of Caregiver/Grandparent: ________________________________

Child(ren) living with Caregiver:
1. ____________________________ Age: ____________
2. ____________________________ Age: ____________
3. ____________________________ Age: ____________

Address: ______________________________________________________________________________________

City/State/Zip: ____________________________________________________________________________________

Phone #: _________________________________________________________________________________________

What is your need as a caregiver? __________________________________________________________________

_______________________________________________________________________________________________

What do you need assistance with today? __________________________________________________________________

_______________________________________________________________________________________________

Caregiver Signature: _________________________________ Date: ______________________________

_______________________________________________________________________________________________

Office Use Only

Approved Amount $ ________________ # of Gift Cards Issued: ________________ Date: ________________

Completed By: __________________________________________________________________________________
Respite Invoice

Provider Name: ___________________________ SSN#: __________________

Address: ________________________________ Phone: __________________

City/State/Zip: ___________________________

Choctaw Nation Employee?  □ Yes  □ No
If so, what department? __________________ Kronos #: __________________

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Service Performed</th>
<th>Rate of Pay</th>
<th>Hours</th>
<th>Amount Due</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Due: $___________

Child’s Name: ____________________________

Provider Signature: ______________________ Date: __________________

Caregiver Signature: _____________________ Date: __________________

Please mail all documents and allow up to 30 business days to receive a check.

Choctaw Nation Healthy Aging
1803 Chukka Hina, Durant, OK 74701
(580) 924-7141 extension 83849
gwscott@cnhsa.com or fax (580) 916-9230

________________________________________
Administrative Approval

Signature: _______________________________ Date: __________________
ACH INFORMATION
The following information is provided to the Choctaw Nation for set up of vendor ACH payments.

LEGAL INFORMATION

Business name: 

Tax ID #: 

Only one contact email address is allowed (for notification of pmt): 

* Creating a group EMAIL distribution listing on your side will eliminate an Email notification from not being read or received in a timely manner. The EMAIL notification CANNOT be regenerated or resent.*

Contact Phone #: 

Fax #: 

BANKING INFORMATION

Bank routing/transit #: 

Bank account #: 

Bank name: 

Checking Account ______ or Savings Account ______  (Please check one)

SIGNATURE and TITLE ___________________________  DATE ____________

Your Signature verifies that you are legally authorized to provide this information and that you and the company that you represent will hold harmless the Choctaw Nation of Oklahoma of and from all claims, actions, causes of action and losses, including reasonable attorney fees and court costs, arising out of or in conjunction with any matter regarding this form.

A VOI EED BLANK CHECK, COPY OF A VOI EED BLANK CHECK OR A LETTER FROM YOUR BANK MUST BE INCLUDED WITH THIS FORM. PLEASE NOTE: A DEPOSIT SLIP WILL NOT BE ACCEPTED.
Request for Taxpayer Identification Number and Certification

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 = Corporation, S = S corporation, P = Partnership).
   - 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)

5. Address (number, street, and apt. or suite no.). See instructions.

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.

<table>
<thead>
<tr>
<th>Social security number</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
</tr>
<tr>
<td>-</td>
</tr>
<tr>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer identification number</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
</tr>
</tbody>
</table>

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-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

Cat. No. 10231X

Form W-9 (Rev. 10-2018)