



Choctaw Nation Health Services Authority
Healthy Aging

Respite Program Application

- Pays for a respite care provider to relieve informal family caregivers age 55+ or are a frail elder
- Care recipient or Caregiver 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
- Care recipient must have an informal caregiver
- Temporary assistance until other resources are available
- Must reapply every 6 months
- \$300 max over a 3 month period
- Please submit all documents and allow up to 30 days to receive a check

Caregiver Signature: _____

Respite Signature: _____

Title VI Application / Intake

Care Recipient Information

Name: _____ County of Residence: _____

Address: _____ SSN: _____

City/State: _____ DOB: _____ Age: _____

Phone #: _____ CDIB/Tribe: _____

Who lives in the home: _____

Are you needing chore, personal care, or respite services? (please check)

Describe your needs for provider services: _____

Does the elder qualify for Medicaid / Medicaid Advantage Program? Yes No

If yes, does the elder have a provider through the Advantage Program? Yes No

Are you receiving provider services through other programs? Yes No

If yes, what and who provides the services? _____

Is the elder or spouse a Veteran? Yes No

Do you need transportation to the Community Center? Yes No

Assessment of Care Recipient

Requires assistance with Activities of Daily Living (ADL): (check all that apply)

- | | | |
|------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Dressing | <input type="checkbox"/> Bathing |
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Transferring |

Requires assistance with instrumental ADL: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Preparing Meals | <input type="checkbox"/> Doing Housework | <input type="checkbox"/> Doing Laundry |
| <input type="checkbox"/> Taking Prescriptions | <input type="checkbox"/> Distance Walking | <input type="checkbox"/> Doing Shopping |
| <input type="checkbox"/> 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 SERVICES CONTRACT

AGREEMENT AND RESPONSIBILITIES

I agree to the terms and conditions of this Agreement under the terms and conditions stated within the Agreement. The Agreement is between the Care Recipient, as indicated below, me, the Caregiver, and the Choctaw Nation of Oklahoma, as administrator of the Title VI Caregiver Program. I understand that the Care Recipient may renew this Agreement with the approval of the Choctaw Nation of Oklahoma. As the Respite Provider, I understand and agree that I will provide respite services to the Care Recipient for a period of _____ hours per week at a rate of \$_____ per hour, subject to approval of the Choctaw Nation of Oklahoma as the administrator of the program.

Terms of the Agreement include the following:

1. Caregiver will assist the Care Recipient by invoicing the Choctaw Nation of Oklahoma including information on the hours, rate and total due each week;
2. Submit the invoice with a signature of the Care Recipient or their legal guardian to verify and approve the invoice for payment;
3. Submit a W-9 IRS form with this application with a copy of a valid photo ID;
4. Assist Care Recipient in application for long-term care, if needed;
5. Acknowledge that this Caregiver Program is for short-term assistance, requiring renewal at least every six months; and
6. Agrees that invoice payments will be received within 30 days from receipt by the Choctaw Nation of Oklahoma.

By affixing signature below, Caregiver, Care Recipient and Respite Provider hereby release the Choctaw Nation from any liability with regard to tort or any cause of action resulting in damage to person or property, with the understanding that the Choctaw Nation bears to responsibility for the acts of any third party not directly employed by the Choctaw Nation. The Choctaw Nation is merely paying the Respite Provider to provide for services on behalf of the Caregiver under a benevolent program, being under no obligation to do so.

Respite Provider is considered an independent contractor and not an employee of the Choctaw Nation of Oklahoma. The Choctaw Nation is not responsible for withholding taxes, insurance, Worker's Compensation or any other benefit bestowed upon any definition of a statutory employee. Payment from the Choctaw Nation for services rendered under this Agreement shall not constitute employment nor provide any legal basis for indemnification for acts or omissions committed by the Respite Provider in furtherance of their duties or actions under the terms and conditions of this Agreement.

CAREGIVER INFORMATION

Name: _____ SSN: _____

Address: _____ Cell #: _____

City/State/Zip: _____ Date: _____

Signature: _____

RESPITE PROVIDER INFORMATION

Name: _____ SSN: _____

Address: _____ Cell #: _____

City/State/Zip: _____ Date: _____

Signature: _____

Choctaw Nation APPROVAL: _____ Date: _____

In Home Assessment

Activities of Daily Living (ADL)

Client's Name: _____

Do you need assistance with:	No Assistance (0)	Some Assistance (2)	Cannot Do at All (3)
Dressing: Getting out of clothes, putting them on, fastening them, and putting on shoes	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Bathing: Running the water, taking the bath or shower, and washing all parts of the body	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Eating: Eating, drinking from a cup and cutting food	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Transferring: Getting in and out of a bed or chair	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Toileting: How well can you manage using the toilet? Independent toileting includes adjusting clothing getting to and on or off the toilet and cleaning self if accidents occur. If client manages alone, count as no assistance. If reminders are needed to use the toilet, count as some assistance.	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Walking: Walking, the ability to move around inside the home or on stairs	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
ADL Score (add checked numbers):	Total:		

Instrumental Activities of Daily Living (IADL)

Do you need assistance with:	No Assistance (0)	Some Assistance (2)	Cannot Do at All (3)
Transportation Ability: Includes using local transportation or driving to places beyond walking distance	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Prepare Meals: Preparing your own meals, including sandwiches or cooked meals	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Light Housekeeping: dusting, vacuuming, sweeping, etc.	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Shopping: Includes grocery shopping, essentials	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Medication Management: Prescriptions management includes taking your own medications, keeping track of when/how much of each to take	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Money Management: Able to responsibly follow your own money, keeping track of & paying bills	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Telephone Usage: Answering phone/TDD, making calls	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Heavy Housekeeping: Yard work, laundry, tasks requiring more strength or endurance and fine motor skills	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 3
IADL Score (add checked numbers):	Total:		
IADL Impairment:			

Score Tally	
Does client live alone? (if yes, add 1 point)	
ADLs – enter score from that table	ADL Score:
IADLs – enter score from table above	IADL Score:
Does client receive any assistance/services (formal or informal) in ADL or IADL areas?	<input type="checkbox"/> none – add 3 points <input type="checkbox"/> some available, but inadequate/unreliable, etc. – add 2 points <input type="checkbox"/> if adequate assistance – add 0 points
Total Score:	

Risk Category: Low (0-3 points) Moderate (4-13 points) High (14+ points)

Screeener's Signature: _____ Date: _____

Respite Invoice

BU# 11634051

Provider Name: _____ ABN#: _____

Address: _____ Phone: _____

City/State/Zip: _____ Email: _____

Choctaw Nation Employee? Yes No

If so, what department? _____ Kronos #: _____

Date of Service	Service Performed	Rate of Pay	Hours	Amount Due

Total Due: \$ _____

Patient 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
JMUnderwood@cnhsa.com or fax (580) 916-9230

Administrative Approval

Signature: _____ Date: _____



TW ACH Information Form

P.O. Box 1210
Durant, OK 74702-1210
Email: PEID@choctawnation.com

ACH INFORMATION

I (we) hereby authorize The Choctaw Nation of Oklahoma, hereinafter called "Nation," to initiate credit entries and, if necessary, debit correction and adjustment entries to my (our) account at the financial institution listed below, hereinafter called "Depository." I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of applicable federal and state laws, rules, and regulations.

Legal Information

Legal Business Name: _____

Tax Identification #: _____

Contact Email: _____
(Automated payment notification only)

Banking Information

Depository name: _____ Branch: _____

Depository Routing & Transit Number: _____

Depository Account Number: _____

Address: _____
City State ZIP

Account Type: Checking Savings

This authorization is to remain in full force and effect until Nation has received written notification from me (or either of us) of its termination in such a time and manner as to afford Nation and Depository a reasonable time to act upon it.

Signature and Title

Date

Please attach a voided check or financial institution account verification letter to this form.

