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)

☐ 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 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	☐ 0	☐ 2	☐ 3
Bathing: Running the water, taking the bath or shower, and washing all parts of the body	☐ 0	☐ 2	☐ 3
Eating: Eating, drinking from a cup and cutting food	☐ 0	☐ 2	☐ 3
Transferring: Getting in and out of a bed or chair	☐ 0	☐ 2	☐ 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.	☐ 0	☐ 2	☐ 3
Walking: Walking, the ability to move around inside the home or on stairs	☐ 0	☐ 2	☐ 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	☐ 0	☐ 2	☐ 3
Prepare Meals: Preparing your own meals, including sandwiches or cooked meals	☐ 0	☐ 2	☐ 3
Light Housekeeping: dusting, vacuuming, sweeping, etc.	☐ 0	☐ 2	☐ 3
Shopping: Includes grocery shopping, essentials	☐ 0	☐ 2	☐ 3
Medication Management: Prescriptions management includes taking your own medications, keeping track of when/how much of each to take	☐ 0	☐ 2	☐ 3
Money Management: Able to responsibly follow your own money, keeping track of & paying bills	☐ 0	☐ 2	☐ 3
Telephone Usage: Answering phone/TDD, making calls	☐ 0	☐ 2	☐ 3
Heavy Housekeeping: Yard work, laundry, tasks requiring more strength or endurance and find motor skills	☐ 0	☐ 2	☐ 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?	☐ none – add 3 points ☐ some available, but inadequate/unreliable, etc. – add 2 points ☐ if adequate assistance – add 0 points
Total Score:	

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

Screener's Signature: _____ Date: _____

Respite Invoice

BU# 11634051

Provider Name: _____ ABN#: _____

Address: _____ Phone: _____

City/State/Zip: _____

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

Administrative Approval

Signature: _____ Date: _____

CHOCTAW NATION OF OKLAHOMA

PO Box 1210 ● Area Code 580-924-8280
Durant, Oklahoma 74702-1210
Finance Office

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 VOIDED BLANK CHECK, COPY OF A VOIDED BLANK CHECK OR A LETTER FROM YOUR BANK MUST BE INCLUDED WITH THIS FORM. PLEASE NOTE: A DEPOSIT SLIP WILL NOT BE ACCEPTED.

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)
- 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.*