Choctaw Nation Health Services Authority
Healthy Aging

Supportive In Home Services Application

• Pays for in home services for a homemaker or personal care for age 55+ or are a frail elder. Must meet IADL & ADL requirements. Provider cannot live in the home.

• Care recipient must have a CDIB and live within the Choctaw Nation service area

• Homemaker: *meal preparation  *shopping  *light housework

• Personal Care: assisting with *eating  *dressing  *bathing  
  *transferring  *health related task  *maintaining house

• Personal Care Provider must be a family member or must have certification:  
  *CNA  *home health  *OK Community Service Worker

• Temporary assistance until other resources are available:  
  *home health  *Medicaid advantage  *provider service

• 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: ______________
IN HOME 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 Provider, and the Choctaw Nation of Oklahoma, as administrator of the Title VI Program. I understand that the Care Recipient may renew this Agreement with the approval of the Choctaw Nation of Oklahoma. As the In Home Provider, I understand and agree that I will provide homemaker and/or personal care 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.

As part of this Agreement, I have provided information and attached it hereto, representing the following if I am giving personal care and not a family member:

1. CNA Certification,
2. Home Health Care certification,
3. OK Community Service worker identification, or
4. Other experience or certification for personal care.

(In Home Provider shall attach documentation, including work experience.)

Terms of the Agreement include the following:

1. In Home Provider 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. Agrees that invoice payments will be received within 15-20 days from receipt by the Choctaw Nation of Oklahoma.

By affixing signature below, In Home Provider and Care Recipient 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 responsibility for the acts of any third party not directly employed by the Choctaw Nation. The Choctaw Nation is merely paying the In Home Provider to provide for services on behalf of the Care Recipient under a benevolent program, being under no obligation to do so.

In Home 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 In Home Provider in furtherance of their duties or actions under the terms and conditions of this Agreement.
IN HOME PROVIDER INFORMATION

Name: ________________________________ SSN: ________________________________
Address: ________________________________ Cell #: ________________________________
City/State/Zip: ________________________________ Date: ________________________________
Signature: ______________________________________________________

CARE RECIPIENT INFORMATION

Name: ________________________________ SSN: ________________________________
Address: ________________________________ Cell #: ________________________________
City/State/Zip: ________________________________ Date: ________________________________
Signature: ______________________________________________________
## In Home Assessment
Activities of Daily Living (ADL)

Client’s Name: ____________________________

<table>
<thead>
<tr>
<th>Do you need assistance with:</th>
<th>No Assistance (0)</th>
<th>Some Assistance (2)</th>
<th>Cannot Do at All (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dressing:</strong> Getting out of clothes, putting them on, fastening them, and putting on shoes</td>
<td>□ 0</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td><strong>Bathing:</strong> Running the water, taking the bath or shower, and washing all parts of the body</td>
<td>□ 0</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td><strong>Eating:</strong> Eating, drinking from a cup and cutting food</td>
<td>□ 0</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td><strong>Transferring:</strong> Getting in and out of a bed or chair</td>
<td>□ 0</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td><strong>Toileting:</strong> 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.</td>
<td>□ 0</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
<tr>
<td><strong>Walking:</strong> Walking, the ability to move around inside the home or on stairs</td>
<td>□ 0</td>
<td>□ 2</td>
<td>□ 3</td>
</tr>
</tbody>
</table>

**ADL Score** (add checked numbers):  

**Total:**  

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*Choctaw Nation Division of Tribal Services*
**Instrumental Activities of Daily Living (IADL)**

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

**IADL Score** (add checked numbers):  
Total:   

**IADL Impairment:**

**Score Tally**

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

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

Screener’s Signature: ____________________________ Date: ________________

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**Choctaw Nation Division of Tribal Services**
Chore Invoice

Provider Name: __________________________ ABN#: __________________________
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>
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</tbody>
</table>

Total Due: $________________

Patient Name: __________________________

Provider 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 VOIDED BLANK CHECK, COPY OF A VOIED 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
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=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.

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.