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.
- Elder must be homebound and cannot drive.
- 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

Care Recipient: _____

Care Provider: _____

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 to 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: _____

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: _____

Chore Invoice

BU# 11631111

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: _____

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) 916-9140
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.

Form **W-9**
(Rev. March 2024)
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.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

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

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

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

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

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

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

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

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. See also *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*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they