Caregiver Program

Purpose:

To provide a comprehensive referral and service system for families/individuals who are caregivers to elders who are chronically ill or who have a life altering physical, mental or developmental disability, and grandparents providing care to a grandchild. Services available include information about services, caregiver training, support groups, counseling, assistance to caregivers in gaining services, and respite services to compliment care provided by caregivers.

Procedures:

A. Eligibility

1. Adult family member or another individual caring for frail older persons (55) years of age or older, who have at least 2 assisted daily living needs.
2. Grandparents (55) years or older, who are primary caregivers residing with a child (under 18 years of age), and have a legal relationship with the child or are raising the child(ren).
3. All participants must be a resident of Ottawa County and be an enrolled member of a federally recognized tribe with a valid CDIB card.
4. Care for children under the age of 19 with severe development disabilities or handicap.

Respite Care:

Respite care provides the caregiver with "time off" from their care giving duties. The caregiver chooses his/her own respite worker(s) and determines the rate of pay and number of hours worked per respite worker.

Respite can range from a few hours a day to a week or more. Where respite takes place and the length of time depends on the needs of the family and the available resources. It is usually planned; however, emergency care is sometimes needed.

Respite Contract Services
Agreement & Responsibilities

I, _____, agree to the terms of this agreement and enter into agreement to provide contractual service with _____, a Family Caregiver.

I understand that the Family Caregiver with the approval of the Oklahoma Caregivers Program may from time to time renew this agreement.

I have the responsibility to provide Respite Care for $7.50 per hour*. (Prior approval from the Quapaw Tribe Caregiver Program)

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

- To assist the Family Caregiver by invoicing the Quapaw Tribe of Oklahoma that includes hours, rate and total amount due.
- To submit the invoice with a signature of the Primary Family Caregiver verifying and approving for payment.
- Submit a W-9 IRS form with the initial agreement.
- To assist the Family Caregiver to make application with other agencies for long term respite service.
- I agree to attend at least (2) support group meetings during my respite contract.
- That no change or modification be made to this agreement.

RESPITE PROVIDER_____ DATE_____

FAMILY CAREGIVER_____ DATE_____

CAREGIVER SPECIALIST_____ DATE _____

Caregiver Assessment Tool

Caller Information:

Name: _____ Phone: _____

Address: _____

City/State/Zip: _____

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Care Recipient Information:

Name: _____ Birthdate: _____ SSN: _____

Address: _____

City/State/Zip: _____

Phone: _____ Race: _____ Gender: _____

Recipient is a _____ of the caregiver. (Spouse, Child, Grandchild, Parent, Other)

Number of people in care recipient's household _____ Does recipient live alone? Y N

……

Caregiver Information:

Name: _____ Birthdate: _____ SSN: _____

Address: _____

City/State/Zip: _____

Phone: _____ Race: _____ Gender: _____

The following information obtained from the caregiver:

Diagnosis of Recipient_____ (1-Limited Mobility 2-Stroke 3-Alzheimer's Dementia
4-Depressed/Anxiety 5-Mental Illness 6-Cancer 7-Other)

Services in place _____ (1-Home Health 2-Support Group 3-Transportation
4-Housekeeping/Chore 5-Respite 6-Nutrition
7-Other, please specify _____)

Services Needed_____ (1-Home Health 2-Support Group 3-Transportation
4-Housekeeping/Chore 5-Respite 6-Nutrition
7-Other, please specify _____)

Personal Care Needed: _____ (1-Bathing 2-Dressing 3-Eating 4-Toileting 5-Transferring)

Training Needed: _____ (1-Stress Management/burn-out 2-Caregiving Tips/Strategies
3-Caregivers in the Workplace 4-Safety in the Home
5-Medication Management)

Action Taken/Requested _____ (1-Information/Packet 2-Counseling/Phone 3-Referral
4-Support Group 5-Follow up 6-Heart to Heart Program)

_____ _____
Caregiver Signature Date

_____ _____
Assessor Signature/Organization Date

CAREGIVER SURVEY

1. I have been a caregiver for:
   □ Less than 1 year □ 1-5 years □ 6-9 years □ 10 or more years

2. I care for my:
   □ Spouse □ Parent □ Child □ Grandchild □ Other _____

3. The following would benefit me as a caregiver:
   □ Support Groups □ Newsletter □ Respite Care □ Support by Phone □ Community Presentation

4. I use the following community services:
   □ Senior Center □ Home Health □ Senior Companion □ Home Del. Meals □ Transportation

5. The age of my care recipient is:
   □ 18 & under □ 60-69 □ 70-79 □ 80-89 □ 90 & over

6. My care recipient lives:
   □ In their own home □ Long term care facility □ Other
   _____

7. My care recipient resides:
   □ Alone □ With family □ With friends □ Other _____

8. I work outside of the home: □ Yes □ No

9. The person I care for has been diagnosed with one or more of the following:
   □ Alzheimer's □ Stroke □ Cancer □ Parkinson's □ Heart Disease □ Other
   _____

10. I have access to the internet: □ Yes □ No

11. My age is:
    □ 18-30 □ 31-40 □ 41-50 □ 51-60 □ 61-70 □ 71-80 □ 81-90 □ 91 & over

12. My gender is: □ Male □ Female

13. My race is:
    □ White/Caucasian □ Asian/Pacific Islander □ Black/African American □ Native American
    □ Hispanic □ Other _____

14. My care recipient's race is:
    □ White/Caucasian □ Asian/Pacific Islander □ Black/African American □ Native American
    □ Hispanic □ Other _____

15. My care recipient's gender is: □ Male □ Female

The town I live in is: _____ Zip: _____

If you would like more information on caregiver issues, please fill out the information below:
Name: _____
Address: _____
Phone: _____

RELEASE OF INFORMATION TO & FROM OTHER AGENCIES

(A COPY OF THIS DOCUMENT SHALL HAVE THE SAME PURPOSE AND EFFECT AS THE ORIGINAL)

TO WHOM IT MAY CONCERN:

I, _____, do hereby give permission for
(Print Name)
_____, to release information to
(Name of Agency)
_____

which would be used to benefit me and/or assist in determining my eligibility for services under

_____
(Name of Program or Service)

I also give permission for _____ to release:

_____
(Identify Information)
_____

to the following agencies for the same purpose .
(Names of Agencies which records are to be released)

1.

2.

3.

4.

5.

_____ _____
(Signature) (Date)