Elder Assistance Program

Please check all that apply:

- ☐ I need information about area services available to caregivers or elders?
- ☐ I need educational support; individual counseling or training related to your care giving of loved one.
- ☐ I am a tribal elder seeking assistance with chores and general household duties?
- ☐ I am a caregiver of a tribal elder and would like respite assistance.
- ☐ I am a tribal elder with legal /custodial custody of my grandchildren or children under the age of 18 or care giver to a developmentally delayed /medically fragile individual and I would like respite assistance.
- ☐ I need a medical device prescribed by my doctor and could use assistance to obtain it along with training about how to use the device.

Tribal Elder:

Tribal Elder's Name: _____

Address: _____

Phone Number: _____ Cell Phone: _____

Email: _____

Emergency Contact for Elder: _____

The contact's phone number: _____

Do you have children under 18 living with you? _____

Adult Caregiver:

Caregiver's Name: _____

Address: _____

Phone Number: _____ Cell Phone: _____

Email: _____

What is your relationship to the elder? _____

Emergency Contact for Caregiver: _____

The contact's phone number: _____

Respite Assistance Only

Name of Respite Provider: _____

Address: _____

Phone Number: _____ **Cell Phone:** _____

Email: _____

Emergency Contact for Provider: _____

The contact's phone number: _____

Please provide a copy of the provider's valid driver's license and they need to complete a W-9 form and attach it with this application.

Medical Device Only

Name of Prescribing Physician: _____

Physician's phone number: _____

What is the type of device needed: _____

Where does this device need to be delivered? _____

_____

Please provide a copy of the doctor's prescription for the medical device.

Respite Care for Minors

Number of children in your care: _____

Please list the name and age of children:

_____

_____

_____

_____

Please provide the legal document to prove that you are legal /custodial guardian of these children.

Elder Assistance Program

Tribal Elder Assistance: to better meet your needs and promote your independence we need to ask a few questions. Please check all that apply:

Do you need assistance with household chores and if so please mark all that apply?

- ☐ Mopping or vacuuming the floor
- ☐ Laundry
- ☐ Dusting
- ☐ Cleaning Kitchen and Bathrooms
- ☐ Changing bed linens
- ☐ Ironing
- ☐ Cooking
- ☐ Mowing the lawn
- ☐ Yard clean up

Do you need assistance outside of the home?

- ☐ Grocery shopping
- ☐ Picking up prescriptions
- ☐ Going to the doctor / hair dresser
- ☐ Shopping for clothing or household items
- ☐ Taking pets for a walk or to the vet

After a medical procedure would it help you to have someone stay overnight with you? _____

Do you need assistance with:

- ☐ Personal grooming / bathing
- ☐ Paying bills
- ☐ Reading mail / paperwork

☐ I would like the tribe to assign an elder assistant to help me. I understand this individual has passed a background check and has a valid driver's license.

☐ I have a family member or trusted friend I would like assistance from at this time.

Elder Assistance Program

Caregiver Assistance: to better meet your needs as a caregiver to a tribal elder please take a moment to answer a few questions.

Please check all that apply:

The tribal elder takes medication for:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Alzheimer's
- ☐ Other:_____
- ☐ Cancer
- ☐ Arthritis
- ☐ Mental Illness

The elder receives services from the following area providers:

- ☐ Hospice (Which agency?) :_____
- ☐ Home Health (Which agency?):_____
- ☐ DHS Advantage Program
- ☐ Seneca-Cayuga Tribal Elder Nutrition Program
- ☐ Seneca-Cayuga Community Health Representative
- ☐ Elder assistance services from another Tribe? _____
- ☐ Elder Ombudsman

What assistive devices do the elder use?

- ☐ Glasses /Contacts
- ☐ Hearing Aid
- ☐ Wheelchair
- ☐ Cane
- ☐ Walker
- ☐ Oxygen
- ☐ Pacemaker
- ☐ Dentures

Does the elder need assistance with personal grooming or mobility?

- ☐ Bathing
- ☐ Dressing
- ☐ Eating
- ☐ Toileting
- ☐ Walking or wheelchair
- ☐ Transportation to the doctor

As a caregiver I would like help most with: _____

_____

Elder Assistance Program

Caregiver Assistance for Minors: please provide us with a little information about the children in your home that will be cared for during your respite.

Do any of the children in your home have a medical condition that requires medication or monitoring? _____
If so please list the child's name and condition or meditation with prescribed dosage:_____
_____

Are there any food allergies that the respite provider should be aware of? _____
_____

Are there any behavioral problems that the respite provider should be aware of? _____
_____

How is discipline handled in your home?

- ☐ Time out /standing in the corner
- ☐ Privileges removed

List the interests of the children like stories, games, playtime activities, favorite television shows or hobbies?

Caregiver Assistance for Developmentally Delayed / Medically Fragile: please provide us with a little information about the individual in your home that will be cared for during your respite.

Do any of the individual in your home have a medical condition that requires medication or monitoring? _____
If so please list the condition or meditation with prescribed dosage:_____
_____

Are there any food allergies that the respite provider should be aware of? _____
_____

Are there any behavioral problems that the respite provider should be aware of? _____
_____

List the interests of the individual like games, favorite television shows or hobbies? Use the back of this sheet if you needed.

Elder Assistance Program

Checklist:

- ☐ Application
- ☐ Copy of Tribal Enrollment Card of the Elder
- ☐ Respite care provider valid driver's license (respite care only)
- ☐ Respite care provider W-9 (respite care only)
- ☐ Physician prescription for medical device (medical device only)

Confidentiality and Disclosure of Information: No information about a participant or obtained from a participant by this program will be disclosed in a form that identifies that person without the informed consent of the person or their legal representative unless the disclosure is required by court order or program monitoring by federal funding agencies.

No information will be disclosed that is exempt from disclosure by a federal agency under the Federal Freedom of Information Act, 5 U.S.C. 502

Applicant Acknowledgement: _____ Date: _____