GRAND TRAVERSE BAND ELDER'S PROGRAM
CAREGIVER
AND
OLDER RELATIVE SUPPORT APPLICATION

CAREGIVER PROVIDER

Name: Tribal Id:

Current Address: City: ,Michigan Zip:

Email Address: Contact Number:

Relationship to Elder:

ELDER OR OLDER ADULT (18-54) RECEIVING CARE

Elder's Name: Tribal Id:

Address: City ,Michigan Zip:

Contact number:

Signature of Elder or Older Adult receiving care:

GRAND PARENT AND/OR OLDER RELATIVE MUST LIVE AND BE THE SOLE-PRIMARY CARE PROVIDER FOR A CHILD/REN (CHILD DOES NOT HAVE TO BE FEDERALLY RECOGNIZED)? YES OR NO.

The sole primary care provider is the person responsible for the child/ren health, education, and lives with child/ren.

Child Name: Age: Tribal ID (If Applicable):

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RESPITE CAREGIVER INFORMATION IF NEEDED

Name:

Address: City: ,Michigan Zip:

Email:

CONTACT NUMBER: **CELL NUMBER:**

TEMPORARY OR PERMANENT DISABILITY OR OLDER ADULTS RAISING GRANDCHILDREN		
Length of time you provide care: ☐ Temporary Length_____ ☐ Permanent ☐ over 20 days_____		
Do you receive any type of subsidy, payment or reimbursement for the care you are providing (For: Child or older adult) from an agency? Yes No		
If yes, from which agency:	Phone:	
Duplication of services is prohibited.		

PROGRAM PROVIDES ASSISTANT TO PROVIDERS THAT CARE FOR ELDERS THAT ARE "FRAIL" FUNCTIONALLY IMPAIRED DUE TO COGNITIVE OR OTHER IMPAIRMENT OR OLDER ADULTS RAISING GRANDCHILDREN		
List two Difficult Activities of Daily Living that you provide support ☐ None ☐ All	List two Instrumental activities of daily living that you provide support ☐ None ☐ All	What type of illness does recipier take medication for or been diagnosed with
☐ feeding ☐ dressing ☐ hygiene-bathing	☐ shopping ☐ cleaning ☐ Finances	☐ Dementia ☐ ALS ☐ MS ☐ Cancer
☐ toileting - bladder and/or bowel function ☐ appearance ☐ mobility / transferring	☐ cooking meals ☐ using phone ☐ taking medication	☐ Mental Illness ☐ Parkinson's ☐ Alzheimer's ☐ Mobility_____
☐ walking – stair climbing	☐ Yard work ☐ Transportation	☐ Other_____

Brief description of individuals disability and assistance you are requesting:
I declare that all documentation and statements contained herein are true and genuine. I understand that falsification of any information contained in this application may subject the application to criminal offenses. It may also result in an immediate denial of services.

SIGNATURES	
Signature to release information and (Name) on Purchase Order:	
Signature of applicant:	Date: