



GTB Elders Program



FY 27 Caregiver and Grandparent Support Application

Caregiver Provider

Name: _____ Tribal ID:

Current Address: _____ City: _____ MI ZIP: _____

Email Address: _____ Relationship to Elder: _____

Elder or Older Adult 18-54 receiving care

Elders Name: _____ Tribal ID:

Current Address: _____ City: _____ MI ZIP: _____

Email Address: _____ Contact Number: _____

Signature of Elder or Older adult receiving care:

GRANDPARENT AND/OR OLDER RELATIVE MUST LIVE AND BE THE SOLE PRIMARY CARE PROVIDER FOR A CHILD/REN (THE CHILD DOES NOT HAVE TO BE FEDERALLY RECOGNIZED).

YES OR NO. The sole primary care provider is the person responsible for the child/children's health and education who lives with the child/children

Child Name: _____ Age: _____ Tribal id (if applicable):

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Child Name: _____ Age: _____ Tribal id (if applicable):

Respite Caregiver Information if Needed

Name: _____ Tribal Id:

Current Address: _____ City: _____ MI ZIP: _____

Email Address: _____ Contact Number: _____

Signature of Elder or Older Adult receiving care:

Revision Date: 4/9/2026

2027 Caregiver application

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TEMPORARY OR PERMANENT DISABILITY OR OLDER ADULTS RAISING GRANDCHILDREN

Length of time you provide care:

Temporary Length: _____ Permanent Sole Primary care provider and live with a child/ren 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 recipient 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: