KINSHIP APPLICATION COVER SHEET

Region 9 Area Agency on Aging
2569 US 23 South
Alpena MI 49707
PHONE: 989-358-4616
1-800-219-2273
FAX 989-358-6604
E-mail: mainvilleb@nemcsa.org

Kinship Care is a program for relative care providers caring for related children. **This program funds kinship care providers age 55 and older caring for related children under the age of 18 who are in need of services such as school expenses, recreational activities, clothing, necessary furniture and more.** To help meet the needs of as many kinship families as possible in our 12 county region, requests are limited in amount and number of requests per year.

ELIGIBILITY REQUIREMENTS:

- Applicants must be a relative raising a related child under 18 years of age.
- Resident of the state of Michigan and 55 years of age or older.

INSTRUCTIONS:

Please complete the entire application. All information included will be considered when establishing the extent of need. All information provided will be kept confidential.

- Please include a photocopy of registration, bill expense or other document that assistance is being requested for with this application.
- **An optional Case Worker or School Official Verification form may be requested by your County Commission/ Council on Aging office.**
- Please return the completed application to your County Commission/ Council on Aging:

_____ County Commission/Council on Aging

Address: _____

_____

Fax: _____

Phone: _____

Notification of approval or denial of request will be made by the Commission/Council on Aging via fax.

☐ I as the Kinship Coordinator verify the information on this application is correct.

Kinship Assistance Application

Please Type or Print Clearly All Information Requested

YOUR FAMILY INFORMATION:

RELATIVE CARE PROVIDER'S NAME: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ County: _____

State: _____ Zip: _____ Telephone: (___)_____

Name of Child(ren)'s Parent: Mother _____ Father: _____

Address of the Child(ren)'s Biological Parent:

Mother _____ Father:_____

Does either parent have visitation with the child(ren)? Yes☐ No☐

Is a parent providing income on the child(ren)'s behalf? Yes☐ No☐ $_____ a month

Do you have written legal authority to make health care decisions on behalf of your relative child? Yes ____ No ____

DEPENDENTS:

CHILD'S FULL NAME	BIRTH DATE	AGE	SCHOOL NAME

If your relative child is currently receiving assistance through the Department of Human Services please provide the caseworker's name and contact information. Approval to speak with the caseworker on your behalf requires a signed Release of Information form from DHS.

Caseworker's Name: _____ In What County? _____

Phone Number: _____

A signed Michigan Department of Human Services Authorization to Release Information form has been provided. YES ☐ NO ☐

STATEMENT OF NEED: (Check the type of assistance you need below.)

TYPE OF ASSISTANCE	AMOUNT
☐ Clothing ($200 limit per child)	$ _____
List clothing needs _____	
☐ Furniture	_____
☐ Court Costs for Guardianship	_____
☐ Minor Household Safety Repairs	_____
☐ Respite Care/Daycare	_____
☐ Uncovered Health Costs	_____
☐ School Expenses	_____
☐ Recreation	_____
☐ Transportation	
☐ Other _____	
(Identify need)	$ _____
TOTAL AMOUNT REQUESTED:	

Original receipts must be provided to the Commission/Council on Aging for payment

Is the care of your related child(ren) court ordered or a mutual arrangement?

_____

Provide additional detail of the listed needs above.

_____

_____

_____

_____

Payment Request:

Dependent on request approval by your Commission/Council on Aging, checks may be mailed directly to the school, organization or business providing your needed request.

Bill to:

Agency/Organization/Business:_____

Contact Person: _____

Address: _____

City: _____ Zip Code: _____ Telephone: (____)_____

Financial Information:

Are you currently receiving assistance from any other agency or organization?
Please Circle: ☐ Yes ☐ No

If yes, please list the names of the organizations and the types of assistance that you are currently receiving.

_____

_____

_____

Have you contacted any of the following agencies/organizations for assistance with your current request?

☐ Salvation Army
☐ St Vincent DePaul
☐ County Housing Assistance
☐ Scholarship assistance from school, club, sport organization or church
☐ NEMCSA Weatherization
☐ F.I.S.H. (Iosco Co.)
☐ CSFP/TEFAP (food assistance)
☐ Head Start
☐ Department of Human Services
☐ Call Us for Help
☐ Catholic Human Services
☐ Area Church Group
☐ Other (please note) _____

I verify this information is truthful and accurate. All assistance received will be used for the reasons I state in this application. If the information is falsified or the intended use of the funds was not met, I will re-pay the amount in full and/or be denied further assistance.

Signature of Relative Caregiver: _____

Date: _____

Please have your child's case worker OR an official from your child's school fill out the appropriate verification form. They may fax their completed form to County Commission (or Council) on Aging.

COMPLETION OF THE SOCIAL WORKER OR SCHOOL OFFICIAL FORM MAY BE WAIVED AT THE DISCRETION OF THE COUNTY COMMISSION OR COUNCIL ON AGING.

FOR COA OFFICE USE: COA CONTACT PERSON PLEASE COMPLETE

Commission or Council on Aging Section

REQUESTING COMMISSION OR COUNCIL ON AGING _____

COA CONTACT PERSON _____ PHONE NUMBER _____

SOCIAL WORKER OR SCHOOL OFFICIAL SUPPORT PAPERWORK? WAIVED BY COA _____ INCLUDED WITH APPLICATION _____

CLIENT NAME_____ GRANDCHILD(REN) NAME(S)

_____

_____

Date Application Was Completed & Faxed: _____

TYPE OF ASSISTANCE	**AMOUNT**
Clothing ($200 limit per child)	_____
Furniture	_____
Court Costs for Guardianship	_____
Household Repairs	_____
Respite Care/ Day Care	_____
Uncovered Healthcare	_____
School Expenses	_____
Recreations	_____
Transportation	_____
Other _____	_____
Total Amount Requested:	**$**_____

Is this request from a;

☐ **Contracted fund**

☐ **Region 9 AAA Purchase of Service fund**

NAPIS form filled out and submitted to NEMCSA? Yes ☐ Date _____

Area Agency on Aging Section

Approved Amount: $_____ REQUEST DENIED ☐ (see comments/notes below)

_____

Region 9 AAA Authorized Signature Date

Submission date to grants manager _____

Required COA match (Total divided by 9) _____

COMMENTS/ NOTES:

_____

_____

DHS CASE WORKER VERIFICATION: OPTIONAL - AT THE REQUEST OF COA OR AAA

To the DHS Case Worker:
The individual named below is applying for assistance from the _____ County Commission on Aging. This program provides assistance to kinship caregivers for children. The information you provide will help us verify program eligibility and verification of the need indicated in the application.

Name of Relative Caregiver_____

Your Workplace: _____

Social Services Worker Name and Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____)_____ Fax: (____)_____ Email: _____

Please describe the caregiver's current situation and verify his/her need to the best of your knowledge.

_____

_____

_____

_____

_____

Please describe the services you provide for this caregiver.

_____

_____

_____

By signing below I indicate that all information provided is accurate to the best of my knowledge:

DHS Case Worker Signature_____
Date_____

PLEASE MAIL OR FAX THIS COMPLETED PAGE DIRECTLY TO YOUR COUNTY COMMISSION/COUNCIL ON AGING
Address:
Fax:
Phone:

SCHOOL OFFICIAL VERIFICATION: OPTIONAL - AT THE REQUEST OF COA OR AAA

To the School Official:
The individual named below is applying for assistance from the _____ County Commission on Aging. This program provides assistance to kinship caregivers for children. The information you provide will help us verify program eligibility and verification of the need indicated in the application.

Name of Relative Caregiver_____

School Name: _____

School Official Name and Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____)_____ Fax: (____)_____ Email: _____

Please describe the caregiver's current situation and verify his/her need to the best of your knowledge.

_____

_____

_____

_____

_____

Please describe the services you provide for this caregiver.

_____

_____

_____

By signing below I indicate that all information provided is accurate to the best of my knowledge:

School Official Signature_____
Date_____

PLEASE MAIL OR FAX THIS COMPLETED PAGE DIRECTLY TO YOUR COUNTY COMMISSION/COUNCIL ON AGING
Address:
Fax:
Phone:

Michigan National Aging Program Information System (NAPIS)
Caregiver Client Registration / Enrollment Form

(CONFIDENTIAL INFORMATION)

SECTION 1: Client Contact and Demographic Information

Intake Date	**Client Registration Type** ☐ **Care Recipient** ☐ **Caregiver/Kinship Caregiver**	**Date of Birth**

First Name	**Middle Initial**	**Last Name**

Street Address

City	**State**	**Zip code**

Mailing Address (if different)

County of Residence	**Township of Residence**
Telephone **( ) —**	**Email**

Gender:	**Do you consider yourself to be transgender or gender non-conforming?**	**Sexual Orientation:**
☐ Male ☐ Female ☐ Other ☐ Prefer not to say ☐ No response/Unknown	☐ Yes ☐ No ☐ No response/Unknown	☐ Straight/Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Other ☐ Prefer not to say ☐ No response/Unknown

Do you live alone?	**Household size:**	**Income at or below poverty:**
☐ Yes ☐ No ☐ No response/Unknown	☐ Two people in household ☐ Three people in household ☐ Four or more people in household ☐ No response/Unknown	☐ Yes ☐ No ☐ No response/Unknown

Race, check all that apply:	**Multi-Racial?**	**Ethnicity:**
☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native ☐ White ☐ No response/Unknown	☐ Yes ☐ No ☐ No response/Unknown	☐ Hispanic ☐ Not Hispanic ☐ No response/Unknown

Do you speak a language other than English at home? ☐ Yes ☐ No ☐ No response/Unknown

If you speak a language other than English at home:

What is the language?	**How well do you speak English?** ☐ Very well ☐ Well ☐ Not well ☐ Not at all ☐ No response/Unknown

Have you ever served in any branch of the U.S. Armed Forces, including the Reserves or National Guard? ☐ Yes ☐ No ☐ No response/Unknown	**How did you hear about this program?** ☐ Newspaper ☐ Television ☐ Brochure ☐ Website ☐ Friend ☐ Agency ☐ Physician ☐ Health Care Provider ☐ Other ☐ No response/Unknown

KINSHIP RESPITE CARE CHILD INFORMATION	
Older adult raising child(ren) no more than 18 years old **Total children receiving care:** ☐	*Parent/caregiver of Individual with Disabilities* **Total persons with disabilities receiving care:** ☐

Status of child(ren) in care (Check all that apply):

○ Informal ○ Adoption ○ Guardianship ○ Foster Care

○ Legal Custody ○ Unknown ○ Other _____

Are any of the child(ren)'s parents living with the Caregiver?

○ Yes ○ No ○ Unknown

Reason for Kinship Care

○ Abandonment ○ Divorce ○ Illness ○ Substance Abuse ○ Incarceration ○ Unemployment

○ Teen Pregnancy ○ Mental or emotional illness ○ Death ○ Unknown ○ Other _____

Special Needs:

○ Learning Disability ○ Emotional Impairment ○ Physical Handicap
○ Developmental Disability ○ Unknown

Notes

Signature and Confirmation

I understand that the information provided on this form is confidential and will be used for state and federal reporting requirements, program management, quality assurance, public safety and research. No other use of personal identifying information on this form is intended unless authorized by the Bureau of Aging, Community Living and Supports or by a court order. I understand that client information will not be permitted for review by any unauthorized persons. I understand that a client cannot be refused services based on willingness to provide information for NAPIS.

Signature	Print name of person completing the application
Agency Name	Date