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.

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 ($150. 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 ($150. limit per child)	_____
Furniture	_____
Court Costs for Guardianship	_____
Household Repairs	_____
Respite Care/ Day Care	_____
Uncovered Healthcare	_____
School Expenses	_____
Recreations	_____
Transportation	_____
Other _____	_____
Total Amount Requested:	**$**_____

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

Date request was received _____

Submission date to grants manager _____

NEMCSA accounts payable date _____

Required COA match (Total divided by 9) _____

COA notification of request outcome date _____

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:

CONFIDENTIAL INFORMATION

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Bureau of Aging, Community Living and Supports

NAPIS – NATIONAL AGING PROGRAM INFORMATION SYSTEM
Client Registration Application

Area Agency on Aging	Vendor ID No./Name*	Site ID No.
Region 9 Area Agency on Aging		
Form Date*	Client NAPIS ID No.	

PERSONAL IDENTIFYING INFORMATION

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

First Name	Middle Initial	Last Name

Street Address

City	State	Zip code

Mailing Address (if different)

County of Residence	Township of Residence
Telephone	E-mail

Gender
○ Female ○ Male
○ Other ○ Prefer not to say
◉ Unknown

Do you consider yourself to be transgender or gender non-conforming?
○ Yes ○ No ◉ Unknown

Does client live alone?
○ Yes ○ No
○ Unknown

Client Sexual Orientation:
○ Straight/Heterosexual ○ Lesbian ○ Gay ○ Bisexual
○ Prefer not to say ○ Other ○ Unknown

Household Size
☐ Two people ☐ Three people
☐ Four or more people

Ethnic Origin/Race
○ White ○ Black/African American ◉ American Indian/Alaskan Native
○ Asian ○ Native Hawaiian/Other Pacific Islander ○ Unknown

Is the client Hispanic?
○ Yes ○ No
○ Unknown

Is client multi-racial?
☐ Yes ☐ No ☐ Unknown

If client multi-racial (check all that apply):
○ White ○ Black/African American ○ American Indian/Alaskan Native
○ Asian ○ Native Hawaiian/Other Pacific Islander ○ Unknown

Is client below poverty?
○ Yes ○ No
○ Unknown

Does client a speak language other than English at home? If yes, enter language (see application instructions for list).
○ Yes ○ No
○ Unknown

How well does the client speak English?
○ Very well ○ Well ○ Not well
○ Not at all ○ Unknown

Has the client ever served on active duty in the U.S. Armed Forces, Reserves or National Guard?
○ Yes ○ No ○ Unknown

REGISTERED SERVICES

CARE RECIPIENT SERVICES Clusters 1 & 2			
Case Management	Start Date mm/dd/yyyy	Home Health Aide	Start Date mm/dd/yyyy
Case Coordination & Support	Start Date mm/dd/yyyy	Homemaker	Start Date mm/dd/yyyy
Chore Services	Start Date mm/dd/yyyy	Options Counseling	Start Date mm/dd/yyyy
Home Delivered Meals	Start Date mm/dd/yyyy	Personal Care	Start Date mm/dd/yyyy
Assisted Transportation	Start Date mm/dd/yyyy	Nutrition Counseling	Start Date mm/dd/yyyy
Congregate Meals	Start Date mm/dd/yyyy		
CAREGIVER SERVICES Cluster 4			
Adult Day Care	Start Date mm/dd/yyyy	Caregiver Counseling	Start Date mm/dd/yyyy
Caregiver Supplemental Service	Start Date mm/dd/yyyy	Caregiver Support Group	Start Date mm/dd/yyyy
Caregiver Training	Start Date mm/dd/yyyy	Chore Service – Respite	Start Date mm/dd/yyyy
Home Delivered Meals – Respite	Start Date mm/dd/yyyy	Home Health Aide – Respite	Start Date mm/dd/yyyy
Homemaker Respite	Start Date mm/dd/yyyy	In-Home Respite	Start Date mm/dd/yyyy
Kinship Respite	Start Date mm/dd/yyyy	Out of Home Respite	Start Date mm/dd/yyyy
Overnight Respite	Start Date mm/dd/yyyy	Personal Care Respite	Start Date mm/dd/yyyy
Volunteer Respite	Start Date mm/dd/yyyy		

CARE RECIPIENT AND CAREGIVER NON-REGISTERED SERVICES Clusters 3 & 5			
Client identifying information is not required in NAPIS for Clusters 3 and 5 services. No client registration is required. Unit and client counts are reported in the aggregate. The option to include client details in NAPIS is for area agency tracking only. For your record, enter date for start of service.			
Non-Registered Care Recipient			
Assistance Hear Impaired/Deaf	Start Date mm/dd/yyyy	Medicare Medicaid Assist/Prog	Start Date mm/dd/yyyy
Assistive Devices & Technology	Start Date mm/dd/yyyy	Legal Assistance	Start Date mm/dd/yyyy
Counseling	Start Date mm/dd/yyyy	Medication Management	Start Date mm/dd/yyyy
Disaster Advocacy & Outreach	Start Date mm/dd/yyyy	Nutrition Education	Start Date mm/dd/yyyy
Disease Prev/Health Promotion	Start Date mm/dd/yyyy	Ombudsman	Start Date mm/dd/yyyy
Elder Abuse Prevention	Start Date mm/dd/yyyy	Outreach	Start Date mm/dd/yyyy
Friendly Reassurance	Start Date mm/dd/yyyy	Senior Center Operations	Start Date mm/dd/yyyy
Health Screening	Start Date mm/dd/yyyy	Senior Center Staffing	Start Date mm/dd/yyyy
Home Injury Control	Start Date mm/dd/yyyy	Transportation	Start Date mm/dd/yyyy
Home Repair	Start Date mm/dd/yyyy	Vision Services	Start Date mm/dd/yyyy
Information & Assistance	Start Date mm/dd/yyyy		
Non-Registered Caregiver			
Caregiver Case Management	Start Date mm/dd/yyyy	Caregiver Transportation	Start Date mm/dd/yyyy
Caregiver Education	Start Date mm/dd/yyyy	Creating Confident Caregiver	Start Date mm/dd/yyyy
Caregiver Info & Assistance	Start Date mm/dd/yyyy	Home Injury Control	Start Date mm/dd/yyyy
Caregiver Outreach	Start Date mm/dd/yyyy		

NUTRITIONAL RISK INFORMATION

Nutritional Risk Assessment is required for HDM, Congregate Meals, Case Coordination, and Care Management.	Client at high risk: ○ Yes ○ No ○ Unknown	Nutritional Risk Score

Nutritional Risk Check *Nutritional Risk Score is required for Home-delivered Meals, Congregate Meals, Case Coordination, and Care Management. Circle the number in the 'yes' column for those that apply. Total the nutritional score. (Six or more, you are at high nutritional risk.)*		**YES**
1. Does care recipient have an illness or condition that made them change the kind and/or amount of food eaten?	**2**	2 2
2. Does care recipient eat fewer than two meals per day?	**3**	☐
3. Does care recipient eat few fruits, vegetable, or milk products?	**2**	☐
4. Does care recipient have three or more drinks of beer, liquor or wine almost every day?	**2**	☐
5. Does care recipient have tooth or mouth problems that make it hard to eat?	**2**	☐
6. Does care recipient lack enough money to buy foods that they need?	**4**	☐
7. Does care recipient eat alone most of the time?	**1**	☐
8. Does care recipient take three or more different prescribed or over-the-counter drugs per day?	**1**	☐
9. Has care recipient lost or gained ten pounds in the last six months without wanting to?	**2**	☐
10. Is care recipient sometimes unable to physically shop, cook or feed self?	**2**	☐
	TOTAL	

DAILY LIVING ACTIVITIES

This information must be completed if client receives Cluster I services.

Activities of Daily Living (ADLs)	**Instrumental Activities of Daily Living (IADLs)**
Client requires assistance with the following ADLs:	*Client requires assistance with the following IADLs:*
☐ No ADLs ☐ All ☐ Eating/Feeding ☐ Dressing ☐ Bathing ☐ Walking ☐ Stair Climbing ☐ Bed Mobility ☐ Toileting ☐ Bladder Function ☐ Bowel Function ☐ Wheeling ☐ Transferring ☐ Mobility Level	☐ No IADLs ☐ All ☐ Shopping ☐ Handling Finances ☐ Heavy Cleaning ☐ Light Cleaning ☐ Using Public Transportation ☐ Using Private Transportation ☐ Cooking Meals ☐ Reheating Meals ☐ Taking Medication ☐ Using Telephone ☐ Doing Laundry ☐ Keeping Appointments ☐ Heating Home

CARE RECIPIENT STATUS

This information is requested for the person who is being cared for by a Caregiver. NAPIS does not require or capture the name of the individual who is being cared for. Only the date of birth is required for qualification purpose. For your record, you may enter the care recipient's name below.

Care Recipient Date of Birth	Care Recipient Name
1. Does the Care Recipient need assistance with completing two or more activities of daily living?	☐ Yes ☐ No ☐ Unknown
2. Does the Care Recipient have a cognitive impairment? (i.e., Alzheimer's dementia, etc.)	☐ Yes ☐ No ☐ Unknown

How did the Care Recipient hear about this program?

○ Newspaper ○ Television ○ Brochure ○ Friend ○ Agency
○ Web site ○ Physician ○ Health Care Provider ○ Other ○ Unknown

CAREGIVER HISTORY

How did the Caregiver hear about this program?

○ Newspaper ○ Television ○ Brochure ○ Friend ○ Agency
○ Web site ○ Physician ○ Health Care Provider ○ Other ○ Unknown

Caregiver relationship to Care Recipient (check all that apply):

○ Wife ○ Husband ○ Brother ○ Sister ○ Daughter ○ Son ○ Daughter-in-Law
○ Son-in-Law ○ Domestic partner/civil union ○ Parent ○ Grandparent ○ Other relative
○ Non-relative ○ Unknown

How long has the Caregiver provided care to the Care Recipient?

○ 0-6 months ○ 7-12 months ○ 13-36 months ○ 37+ months ○ Unknown

How long does it take to get to the Care Recipient's home?

○ Less than 1 hour ○ 1-2 hours ○ More than 3 hours ○ Caregiver lives with Care Recipient
○ Unknown

Caregiver provides care to the Care Recipient:

○ Daily ○ Several times a week ○ Weekly ○ Less than one day per week
○ Monthly ○ Occasionally ○ Unknown

Doe the Caregiver provide hands-on care to the Care Recipient?

○ Yes ○ No ○ Unknown

If Yes, hands-on care is provided, check the appropriate number of hours and frequency (e.g., 1-3 hours, per week).

○ Less than 1 hour ○ 1-3 hours ○ More than 3 hours ○ Unknown

○ Per Day ○ Per Week ○ Per Month ○ Unknown

Caregiver is employed:

☐ Full time ☐ Part time ☐ Not employed ☐ Unknown

Caregiver's health is:

○ Excellent ○ Good ○ Fair ○ Poor ○ Unknown

The caregiver provides care to (how many) care recipients? ☐

Is this a Kinship Respite Care family situation? If Yes, complete the Kinship Respite Care Child information section on next page.

○ Yes ○ No ○ 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