Bay Mills Indian Community
12140 West Lakeshore Drive
Brimley, Michigan 49715
(906) 248-3241 Fax (906)248-3283

TITLE VI ELDER INTAKE FORM

TELEPHONE SCREEN "Confidential Information" ___________
DIRECT CONTACT ____ **LOCATION:**______________________
Initial Intake Date:________________ Renew:________________

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1. MEMBER & CONTACT INFORMATION

Applicant Full Name:____
Last Name *First Name* *Middle Name*

DOB:______________________ Age:_________
Gender:__________Male __________Female

Bay Mills Tribal Member_______YES ______NO TRIBAL ID #___________________

Marital Status: ______Married ______Divorced/Separated ______Widowed _______Single

2. CONTACT INFORMATION

Home Ph::______________Cell:___________Message Ph:__________________
EMAIL Address:____

Physical Address:___________________________Mailing:________________
City:_______________________________________State:_______ Zip Code______________
Directions to Home:____

3. SPOUSE/EMERGENCY/CAREGIVER CONTACT INFORMATION

Spouse's Name:____DOB:______________
Home phone if different from above):___________________________Cell:______________
Tribal Member:_______Yes ______No Tribal Affiliation:_________________
Address/Mailing (if different):____

Name of Emergency/Caregiver:____
Relationship:____
Home Phone:___________________________________Cell:___________________

Name:________________________ Initial Application:__________ Renew Date:__________

4. Legal Status (Guardian, Durable Power of Attorney)

Name:________________________________

Current Status (Duration; start/end date or Permanent):__________________

____

5. COMMUNICATION INFORMATION

Primary Language: ______Ojibwe ______English ______Spanish ______Other

Hearing Impairment: ________Yes ______No If yes, explain:________________

____

Vision Impairment: _________Yes ______ No If yes, explain________________

____

Does the Elder have basic literacy skills? (those necessary to perform simple and everyday literacy activities): _______Yes ______No

6. TRANSPORTATION INFORMATION

Primary Transportation: _______Drives Own Transportation _______Family/Friends ________ Uses Tribal Transportation _______Other

Concerns/Issues: ____

____

7. HOUSING INFORMATION

Type of Housing:____House _____Apartment______ Community Living______ Other:____

Number in Household:_______ Grandchildren in Household: ______No _____ Yes How Many________

Are you the main caretaker of your grandchildren? _______Yes ______No

Duration of time in your care (Temporary or Permanent)____________________

____

Do you have any concerns relating to living situation? ____________________

____

Name:______________________ **Initial Application:**____________ **Renew Date:**____________

8. HEALTH INFORMATION:

The elder has the following Chronic Health Concerns:

_______Asthma _______Alzheimer's _______Arthritis _______Cancer

_______Chronic Pain _______Dementia _______Diabetes _______Mobility

_______Heart Disease _______High Cholesterol _______Hypertension

Elder's concerns:____
____

Family Physician or Primary Medical Provider/Location: ____________________

9. DISASTER or EMERGENCY INFORMATION:

In emergency, elder should be priority: 1 _____(high) 2_______ 3______(low)
Does elder need emergency water? ______YES ______NO

10. DIETARY INFORMATION:

In need of home-delivered meals (frail or homebound): ______YES ______NO
(If yes, continue to Home-Delivered Meal Application)

11. CAREGIVER INFORMATION:

Caregiver Name/Schedule:_______________________________________

Caregiver is: _______Paid _______Unpaid _____Related ______Not Related
(If unpaid, continue to Respite Care Program)

12. VETERANS SERVICE:
Have you ever served in the Military or married to someone in the Military? ____Yes
_____NO

13. What are some critical needs that you have right now relating to Health, Housing, Nutrition, Legal or other support services?____________________
____
____

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Bay Mills Community Elder Caregiver Program
Title VI – Support Services for Nutrition, Support Services & Family Caregiver Support Services

THE REFERRAL FORM should be filled out by the elder, caregiver, or a service organization on your behalf to request supportive services such as home care, lunch delivery, health needs, home repair, or more information about a service of interest or need.

THE ELDER INTAKE FORM is required for each elder in the community receiving nutrition, supportive, or caregiver services.

HOME DELIVERED MEAL APPLICATION: Your consent is required due to CONFIDENTIALITY and PROTECTION of personal information to be shared with ONLY the service provider named. Upon receipt of the application with your consent, the elder care coordinator will assist you in obtaining your medical provider's signature to verify the need for Home Meal Delivery.

THE CAREGIVER PROGRAM APPLICATION: this form is filled out if you are in need of supportive services or if you are a Caregiver of an elder. **Note the type of caregiving support needed on the Elder Intake sheet.** A follow-up call with assistance will be provided in filling out this application. The Elder Caregiver Support Program will provide one-on-one assistance with caregiver/s and families to help navigate resources, information, training, and, most of all, to connect each of you to available community resources locally and with other service providers based on your concerns, needs, and interests.

Please fill out the Elder Intake Form and return it (3) ways:

1. For Home Delivered Meal Participants: hand deliver at the time of home delivery. If you need assistance, a follow-up call will be made.
2. For Congregate Meal Participants: Return Applications to me Tuesday—Thursday during lunchtime: 12:00 pm—1:00 pm (DROPBOX)
3. All tribal Elders will receive this newsletter for your information & can fill it out. Return the form by mail OR to the Senior Center OR drop it off at the Bay Mills Tribal Office.

Questions? Call Joanne Ashley (Cell) 928-637-3946 or (Work) 906-248-8113.

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Bay Mills Care-Giver Support Program

Date of Referral:	Referred From: (Name, Title, Agency):
REFERRED TO (Name, Title, Agency):	
Name of Person Referred: Mailing Address: Main Telephone (Cell or Landline):	DOB/Age: Physical Address: Message Telephone (cell or landline)
Reason for Referral (concerns and/ needs:	
Health status/Physician: Supportive Services provided at present (Caregiver, Tribal program, Organization/s. Duration of service/s, Living independently or cared for by family, relative, other. Specialized Care or Person with disability & equipment need (if applicable):	
Follow up Action with Date/s (filled out by BMIC Personnel)	

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Bay Mills Care-Giver Support Program

Bay Mills Indian Community Care Giver Support Program

RELEASE OF INFORMATION TO AND FROM OTHER AGENCIES

(a copy of this document shall have the same purpose and effect as the original)

TO WHOM IT MAY CONCERN:

I, ________________________________ do hereby give permission
(Print Name)
for ________________________________ to release information
(Name of Agency)
to Bay Mills Elder Care Giver Program / Coordinator

which would be used to benefit me and/or assist in determining my eligibility for services under

BAY MILLS INDIAN COMMUNITY CARE GIVER SUPPORT PROGRAM

I also give permission for BMIC Care Giver Coordinator to release

____
(Identify Information)
____

to the following agencies for the same purpose
(Name of Agencies/Individuals which records are to be released)

1) ________________________________ __________ **(Initials)**

2) ________________________________ __________ **(Initials)**

3) ________________________________ __________ **(Initials)**

4) ________________________________ __________ **(Initials)**

SIGNED: ________________________________ **DATE:** __________

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TITLE VI: HOME DELIVERED MEAL INFORMATION SHEET

Last Name____________________**First**____________________**Middle**__________
Referred by:____________________________________**Date:**______________
Address:____
Telephone:____
Directions to home/Identifying Landmarks/Color of house:
____

DIETARY INFORMATION:

1.In need of Home-Delivered Meals (frail or home-bound):
_______**YES** _________**NO**

2. Elder is unable to leave home without assistance because (describe illness, disability, frailty): ____
____

3. Special Considerations/Instructions (Food Allergies if any):
____
____

MEAL INFORMATION:

Days of the week for Meal Delivery. (NO Meal on Monday)
________**Tuesday** ________**Wednesday** ________**Thursday** _______**Friday**

Do you own dog/s that could interfere with the delivery? _______**YES**______**NO**
If YES, steps taken to address a SAFE meal delivery__________________________
____

NOTE: I understand a consent from a physician is required. I give consent to provide information to the Bay Mills Care Giver Program regarding my Dietary Needs and any Special Considerations *(see attached Consent Form).*

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TITLE VI HOME DELIVERED MEAL GUIDELINE & PHYSICIAN DOCUMENTATION

It is required that we follow the Administration on Aging (AoA) Title VI Nutrition Services (Elder Lunch Program) established guidelines. As stated in the Title VI Resource Manual:

Elders should ONLY be on the HOME DELIVERED PROGRAM if they are unable to leave their homes without great difficulty due to illness, disability or general frailty and have a physician's signature and statement on file. (Delivered meals will not be left at the home if the participant is not there).

Congregate lunch meals (Pick-up of lunch during this Pandemic are served at noon at the Armella Parker Elders Center on: **Tuesday, Wednesday, Thursday and Friday**. We encourage all elders to attend.

NAME OF PATIENT:____
Last First Middle

DATE OF BIRTH:____

PHYSICIAN NAME:____

NAME OF HOSPITAL/CLINIC:______________________________________

Medical Condition:____

____

Any concern to medication reactions:_______________________________

____

Special Dietary Considerations/Instructions:__________________________

____

Medical Care Provider Signature:_________________________________

Date:____