2021 Adult Services Program

NOTICE

Misrepresentation of information on your application is fraud. The Family Services Department will pursue legal action against anyone found to be fraudulently providing inaccurate information on any application.

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PLEASE NOTE:

Applications for financial assistances from the Family Services Department will be subject to internal PCI audits to ensure compliance with the General Welfare guidelines. **This does not apply to services such as In-Home Care, Homemaker Aide Services, Abuse Prevention program or Child Care.**

_____ _____

Signature Date

POARCH BAND OF CREEK INDIANS
FAMILY SERVICES DEPARTMENT
5811 Jack Springs Road
Atmore, AL 36502

Phone: (251)-368-9136 Ext. 2600
Fax: (251) -368-0828

2021 Adult Services Intake / Application

Date: _____

Personal Information

First Name:	MI:	Last Name:	SS #:
Address:	City/State/Zip		Tribal Roll Number:

Contact Information:

Phone: _____
Cell: _____
Other: _____

Marital Status:

- ❑ Single
- ❑ Married
- ❑ Separated
- ❑ Divorced
- ❑ Cohabitating
- ❑ Widowed

Household member that is:

- ❑ Senior Citizen (55 & older)
- ❑ Receiving SSI / Social Security Disability
- ❑ Receiving Veteran's Benefits
- ❑ Receiving Unemployment Benefits
- ❑ Receiving Food Stamps or TANF
- ❑ Child age five (5) or under in your custody
- ❑ Receiving Child Support: Is it ❑ Court Ordered ❑ Voluntary

Insurance:

- ❑ All Kids
- ❑ Medicaid
- ❑ Medicare
- ❑ None
- ❑ Personal
- ❑ Other

Household Information:

Name (include self):	TM#:	DOB:	Age:	SS #:
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Please state the purpose of this application: _____

_____

_____

_____

_____

****FSD Staff Only**

Program Information

CCDF: _____ **CSBG:** _____ **LIHEAP:** _____ **CLIHEAP:** _____

CLIENT'S STATEMENT OF UNDERSTANDING, RIGHTS, AND RESPONSIBILITIES

Consent for Services: I do hereby voluntary request assistance from Poarch Band of Creek Indians' Family Services Department. I understand my application for services will be evaluated for eligibility of services based on program guidelines. I authorize the Family Services Department to make any necessary investigation of my financial situation, household composition, work-related information, and need for assistance to obtain information relating to my eligibility for program services.

I understand I have ten (10) working days to bring in all necessary documentation to complete my application; otherwise the application will be denied. After furnishing all necessary documentation for the completion of my application, I understand I will be notified in writing or by phone about the status of my application within five (5) working days.

Authorization for Release of Information: I give authorization for the release of applicable information to my employer, PCI Departments, CIE Enterprises or Service Provider, as deemed necessary, to assist in the determination of eligibility for services. I understand the contents to be released are for gathering information to receive services; and that there are regulations and rules protecting this information. I hereby acknowledge that my consent for release of information is voluntary and is valid until such request for information is fulfilled. I further understand that I may revoke this consent at any time except to the extent that information has already been released before I revoked my consent. I further understand that I may withdraw my application or request for services at any time.

Fair Hearing: I understand I have the right to request a Fair Hearing on any action taken on my application for services of which I consider improper or about any unreasonable delay in a decision on my application. The request for a Fair Hearing must be made in writing or verbally **(Revised 1/1/2010)** to the Family Services Department within 30 days of the date of the application. As a part of the Fair Hearing process an administrative review of the application will be made with a written response provided within ten (10) working days. If not satisfied with the decision, I understand an appeal must be filed within 30 days of the Administrative Decision.

Penalty Warning: To receive program services, I understand my household must follow the application guidelines. I have been informed that any person who knowingly, willingly, and fraudulently provides false information for the purpose of obtaining benefits for which he/she is not eligible to receive, he/she may be subject to prosecution to fullest extent of the appropriate tribal, state, or federal law. The penalty for misrepresentation of information is a $10,000 fine, imprisonment up to five (5) years or both.

Confidentiality: The information provided to the Family Services Department is considered confidential. The use or disclosure of information will be made only for certain limited purposes. After the application process, no information will be released to an employer, agency, family member, or anyone else unless it has been requested by you and we get permission from you to send the information.

There are rare situations in which releasing information without prior permission is legally possibly. In these situations, we would report in your record what has been released and why. The situations in which releasing information without your permission could occur include the following:

1. If the health or safety of you or someone else in your household is in serious danger.
2. If the Court orders that we release information in a legal action brought against you.
3. If you bring legal action that in some way connects our information to your treatment.
4. If you have been assigned a legal guardian or if you have authorized someone with a power of attorney so that person can get information released about you.
5. If our client records must be reviewed or audited to follow government regulations.
6. Government reviewers sometimes require the use of non-identifying client information for planning purposes.

I declare that I have read or had read to me all the information on the application. All forms have been filled out to the best of my ability. By signing this application, I am stating that everything I have provided is true and correct to the best of my knowledge.

_____ _____

Signature of Applicant/Authorized Representative Date

_____ _____

FSD Worker Date

2021 Poarch Band of Creek Indians Adult Services Case Plan

Client: _____ Date: _____ TM#: _____

Emergency Contact Name(s) & number: _____

Precipitating Crisis or Reason Why Services Are Needed: _____

_____

Plan of Action: (check all that apply)

	Attendant Care
	Homemaker Aide
	Assisted Living Supplement Program
	Case Management

Notes: _____

_____

By signing below you (the client) agree, understand and will cooperate with the developed plan by the Family Services Adult Services Coordinator.

_____ _____

Client Signature **Date**

_____ _____

Caregiver Signature **Date**

_____ _____

Adult Services Manager **Date**

_____ _____

Adult Services Coordinator **Date**

Sign & Return

Poarch Band of Creek Indians
Family Services Department
5811 Jack Springs Road
Atmore, AL 36502
Phone: (251) 368-9136 Ext: 2600
Fax: (251) 368-0828

2021 Adult Services In-Home Program Travel Information

In addition to the In-Home services, the Poarch Band of Creek Indians (PBCI) has extended the program to include transportation for qualified clients.

Your providing agency has now been approved to receive payments for assistance with light transportation. Light transportation is defined as:

- Local transportation up to 100 miles per shift which includes grocery shopping, medical appointments, prescription pick-up and local social outings.

- Any travel above 100 miles is restricted to medical treatment only and must be approved through the Family Services Case Plan.

The agency's employment shall primarily use the client's own vehicle for transportation. If the client does not have a vehicle or the vehicle is not available then agency's employee may use his/her own vehicle to transport the client.

If an agency's employee uses his/her own vehicle to transport client, it would then be the agency's responsibility to confirm that the employee has automobile liability insurance applicable to the vehicle that will be used for transportation.

PBCI will pay the Provider for the hours used for travel that does not exceed 25% of the total weekly hours allowed for the client's services. Any additional costs including mileage will be paid by the client.

By signing below, I declare that I read or had read to me all the above information.

_____ _____
Signature of Applicant/Authorized Representative Date

_____ _____
Family Services Department Worker Date

Sign & Return

Poarch Band of Creek Indians

Family Services Department
5811 Jack Springs Road
Atmore, AL 36502
Phone: 251-368-9136 Ext: 2600
Fax: 251-368-0828

2021 Medical Referral

Dear Physician,

Your patient has applied for services through the Poarch Band of Creek Indians Family Services Department. We appreciate your assistance in taking the time to complete the brief medical referral form and returning it to: Michealine Deese, Adult Services Coordinator (251)368-9136 ext. 2603 or Hannah Martin, Adult Services Case Manager (251)368-9136 ext. 2061. This documentation may be returned to our office via the patient, postal services, by fax: 251-368-0828 or by email to mdeese@pci-nsn.gov or hmartin@pci-nsn.gov .

Patient Name: _____ Date of Birth: _____ Tribal Number: _____

Address: _____

Phone Number: _____

Name of Facility/Doctor: _____

Address: _____

Phone Number: _____ Fax Number: _____

Name and explain the type of disability or condition(s) the patient in brief terms:

_____

1. Will the condition or disability improve or decline? Improve or Decline
2. Can this patient perform their own ADL's? Yes or No
3. Can this patient keep up housekeeping chores? Yes or No
4. Which service are you referring this patient for (choose one)? Homemaker Aide or In-Home Services
5. How many hours will this patient receive weekly? **40 hours** (declining ADL's) **or** **50 hours** (severe-dementia etc.)
6. How long should this patient need services? _____

_____ _____ _____
Printed Name of Physician Signature of Physician Date

Take to Physician and Return Completed

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- Local transportation up to 100 miles per shift including; grocery shopping, medical appointments, prescription pick-up and local social outings.

- Any travel above 100 miles is restricted to medical treatment only and must be approved through the Family Services Case Plan.

The agency's employee shall primarily use the client's own vehicle for transportation. If the client does not have a vehicle or the vehicle is not available then the agency's employee may use his/her own vehicle to transport the client.

If the agency's employee uses his/her own vehicle to transport client it would then be the agency's responsibility to ensure that the employee has automobile liability insurance applicable to the vehicle that will be used for transportation.

PBCI will pay the Provider for the hours used for travel that does not exceed 25% of the total weekly hours allowed for the client's services. Any additional costs including mileage will be paid by the client.

Client Copy

2020-2021 Family Services Department
In-Home Services Program (IHSP) Fact Sheet

**Please note that this is just a facts sheet for the IHSP if you would like a more detailed description of this program we will provide it for you upon your request. **

Program Description: The In-Home Services program will be utilized to assist with payments for Assisted Living Services and the Attendant Care Program for eligible Poarch Band of Creek Indians (PBCI) Tribal Members. The Attendant Care Program Services will be provided in the home of eligible PBCI Tribal Member(s) and/or Tribal Member household which is determined according to the Family Services Department's individual case plan. These services are not limited to the Tribe's designated service area.

In-Home Program Assistance must be related to the performance of his/her activities of daily living (ADL's), instrumental activities of daily living, and/or personal care. This must be provided according to one or more of the following:

- Client(s) have medical documentation of severe mobility limitations' which requires assistance from another person to transfer from one location to another.
- Have medically verifiable increased fall-risk as determined through an assessment completed by a licensed physical therapist due to medically verifiable deteriorating health conditions.
- Have medical documentation of severe Dementia or Alzheimer's disease requiring twenty-four (24) hour supervision.
- Be unable to leave the home to participate in routine social functions or travel on extended trips (defined as two or more days) away from home.
- Have a caregiver in the home that is providing full-time care for the disabled household member.
    - ***Immediate family members of the disabled person are not eligible to be hired to provide the services for the disabled household member.***

Immediate Family Member as defined in the Tribal Ethics Code:

"Immediate family member" qualifies as spouse, parent, child, sibling, grandparent, and/or grandchild. These relationships are determined by consanguinity, affinity, foster care, or legal guardianship.

- Be permanently or temporarily disabled PBCI Tribal Members who live alone without available family support and have a verifiable medical need for ADL's.

Program Description Continued:

- Have provided only one application per tribal household which verifies household constitution, copies of all household member's Social Security Cards, and identification cards for all adults living in the home and PBCI Tribal ID card(s).
- Have verified the medical condition signed by a physician.
- Have chosen an In-Home service provider agency that has signed a Provider Services Agreement with the PBCI Family Services Department.
- Have signed a financial agreement or contract and a care plan with their chosen agency.
- **Clients** sign the agency's billing contract, **not the PBCI Family Services Department.**

Note: The PBCI Family Services Department only pays a maximum rate of $20.00 an hour including holidays. It is the client's responsibility to pay for anything over their approved hours and to cover the exceeded pay rate that the PBCI Family Services Department does not cover.

When approved, the client will receive an award letter verifying the eligibility and the hours of services authorized to be paid for to the agency. The Family Services Department will monitor the provision of services routinely.

Grievance Process:

If there is any disagreement about a denial of assistance regarding the amount of assistance provided, the applicant must initiate the grievance process by submitting a letter in writing to the Family Services Department within ten (10) business days of the denial. When the signed letter is logged in with the date of time of receipt, it will be reviewed by the Family Services Director with information from the Adult Services Coordinator and any other involved staff. A written response will be provided to the applicant within ten (10) business days.

If there continues to be questions or disagreements about a denial of assistance or the amount of assistance provided; then the applicant must submit a letter to the Tribal Member Services Division Director within ten (10) business days after the decision of the Family Services Director is made, requesting a review of the case file, and documents. Once the Tribal Member Services Division Director can agree with the decision of the Family Services Department or make recommendations regarding the approval of a dollar amount of assistance to be provided; a written response will be provided to the applicant with five (5) business days.

CLIENT COPY