The Klamath Tribes
Community Services Department
Native American Respite Relief Caregiver Application

Today's Date_____ ***Director Approval/Date**_____

Name_____ Phone #_____

Mailing Address_____

Physical Address_____

Date of Birth_____ Social Security #_____

Person(s) needing care:

Name_____

Physical Address_____

Mailing Address_____

Phone #_____

Will you be driving this person while performing Respite Care? ☐YES ☐ NO

If yes, we will need a copy of your valid Drivers Liscence & Proof of Insurance.

Primary Caregivers

Name_____

*Write in **None** if you do not have someone to care for.

Do you have a current First Aid, Infant and Adult CPR Training? ☐ YES ☐ NO

If yes, expiration date_____ **(Must provide copy with application)**

Are you currently certified by the State? .....☐ YES ☐ NO

If yes, please list your provider number_____**(Must provide copy with application)**

References:

	Reference Name	Address	Phone #	Caregiver for them
1.				☐ YES ☐ NO
2.				☐ YES ☐ NO
3.				☐ YES ☐ NO

If I am not state certified, I understand that I must apply for, and satisfactorily pass a criminal background Check before I will be approved to be a contracted Respite Care Provider.
(Please fill out Page 2 Consent to Background, Character and Investigation Check)

Signature_____ Date_____

RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize the staff of the Klamath Tribes Department of Community Services to exchange information with the following agencies/programs:

- Klamath Tribes Employment & Education
- Klamath Tribes Housing
- Klamath Tribes Social Services
- Klamath Tribes Health & Family Services
- Klamath Alcohol & Drug Abuse
- Klamath Adult Learning Center /KCC/OIT
- Oregon Adult & Family Services
- Senior & People with Disabilities
- State, Federal, Offices
- Social Service Agencies
- Social Security Administration
- Support Enforcement
- Oregon Department of Employment

I understand that any information obtained may be released to a proper governmental agency, court of law or law enforcement for purposes of legal investigative actions concerning fraud. This release of information will remain in effect while I remain on the Respite Care Program or until I request in writing to rescind such authorization.

_____

Signature of Applicant Date

_____

Print Name

For Office Use by KTRCP

Date Received	Date of Reference Check	CPR Expiration	First Aid Expiration
Date received Drivers License:	Date Rcd. Proof of Insurance		
Date of Approval	State Certified Date / /	or Check Date	Background / /
References Checked (See 1st Page) Name, Date, & Notes 1._____ _____ 2._____ _____ 3._____			