

KINSHIP APPLICATION COVER SHEET

Region 9 Area Agency on Aging
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Alpena MI 49707
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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.

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 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 ___

Kinship Assistance Application

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

TYPE OF ASSISTANCE	AMOUNT
___ Clothing (\$150. limit per child) List clothing needs _____	\$ _____
___ Court Costs for Guardianship	_____
___ Minor Household Safety Repairs	_____
___ Respite Care/Daycare	_____
___ Uncovered Health Costs	_____
___ School Expenses	_____
___ Recreation	_____
___ 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: (____) _____

Kinship Assistance Application

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?

- | | |
|---|---|
| <input type="checkbox"/> Salvation Army | <input type="checkbox"/> CSFP/TEFAP (food assistance) |
| <input type="checkbox"/> St Vincent DePaul | <input type="checkbox"/> Head Start |
| <input type="checkbox"/> County Housing Assistance | <input type="checkbox"/> Department of Human Services |
| <input type="checkbox"/> Scholarship assistance from school, club, sport organization or church | <input type="checkbox"/> Call Us for Help |
| <input type="checkbox"/> NEMCSA Weatherization | <input type="checkbox"/> Catholic Human Services |
| <input type="checkbox"/> F.I.S.H. (Iosco Co.) | <input type="checkbox"/> Area Church Group |
| | <input type="checkbox"/> 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.

KINSHIP ASSISTANCE APPLICATION

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) AND BIRTHDATE(S)

Date Application Was Completed & Faxed: _____

TYPE OF ASSISTANCE

AMOUNT

Clothing (\$150. limit per child) \$ _____

Furniture _____

Household Repairs _____

Respite Care/ Day Care _____

Uncovered Healthcare _____

School Expenses _____

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:

KINSHIP ASSISTANCE APPLICATION

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:

KINSHIP ASSISTANCE APPLICATION

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
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Fax:
Phone: