F

FAMILY

CAREGIVER BENEFIT

PURPOSE

- Support for **persons caring for an elderly or disabled person or child** who has high care needs. The Caregiver must not be in Full Time Employment.
- A payment of **$100** will be paid out on the **1st and the 16th of each month.**

FOR WHOM

- Adults **18 years** and **over.**
- Cook Islander or Non-Cook Islander.
- Residing in the Cook Islands.

APPLY

1. Collect application from Main Office in Tupapa OR phone to have form emailed to you. To download application visit our website **www.intaff.gov.ck**
2. Fill and sign form; attach required documents.
3. Submit complete application to Main Office or email it to: **welfare@intaff.gov.ck**
4. A Welfare Officer will contact you in regards to your application once received—to carry out an Assessment.

For any enquiries please call +682 29370 or send through your query via email above.

YOU NEED

- Passport or Birth Certificate
- Medical Certificate/Report from Registered Doctor—(Medical certificate form will be provided with application form by Internal Affairs)
- Letter from BCI—Confirming Bank Account Details
- Applicant's Valid ID—Drivers License or Passport

TE TANGO AKARANGATIRA ORA'ANGA INTERNAL AFFAIRS

GOVERNMENT OF THE COOK ISLAND

CHECKLIST FOR A CARE-GIVER APPLICATION:

Eligibility:

- ☐ Caring for elderly or disabled who have **High Care Needs**
- ☐ Not in full time employment

Supporting Documents:

- ☐ Passport or Birth Certificate
- ☐ Doctor's Medical Report for the Recipient of Care
- ☐ Assessment by Welfare Inspector
- ☐ Identification of Applicant – Valid Passport/Driver's License
- ☐ Letter from BCI – Confirming Bank Account Details

GOVERNMENT OF THE COOK ISLANDS
MINISTRY OF INTERNAL AFFAIRS
P O Box 98, Rarotonga, Cook Islands * Tel: (682) 29-370 * Fax: (682) 23-608 * E-mail: welfare@cookislands.gov.ck

SOCIAL WELFARE CAREGIVERS APPLICATION FORM

Please complete all questions – if not applicable write N/A.

☐ **New application** ☐ **Reapplying**

PLEASE INDICATE THE TYPE OF ASSISTANCE THE BENEFICIARY IS RECIEVING:

☐ OLD AGE PENSION ☐ CHILD BENEFIT ☐ INFIRM RELIEF

SUPPORTING DOCUMENTS

I have provided all the required supporting documents

☐ Birth Certificate/ Birth Notification
REF: _____

☐ Passport
REF: _____
EXP: _____

☐ BCI Bank Card/ Passbooks
A/C Name: _____
A/C No_____

RMD No#:_____

CAREGIVERS' DETAILS

FIRST NAME: _____

SURNAME: _____

Date Of Birth: _____/_____/_____ **GENDER:** ☐ MALE ☐ FEMALE

ISLAND: _____ **VILLAGE:** _____

Phone: _____ **Mobile:** _____ **Fax:** _____

BENEFICIARIES' DETAILS

NAME: _____

Date Of Birth: _____/_____/_____ **GENDER:** ☐ MALE ☐ FEMALE

RESIDENCY

I (the beneficiary) am a:

☐ Cook Islander born in the Cook Islands

☐ Cook Islander born overseas

☐ Cook Islands permanent resident
Date: _____ / _____ /_____

☐ Other *(please give details):* _____

When did you (the beneficiary) arrive in the Cook Islands: _____/ _____/ _____

YOUR DETAILS (person whom completed the application form)

FIRST NAME: _____ SURNAME: _____

Your relationship to the applicant: _____

Your contact number: _____

The information I have provided is true and complete. The conditions of receiving this benefit/assistance have been explained to me and I understand these conditions.

Signature of applicant: _____ **date**: _____

OFFICE USE ONLY

Statement by Officer: I have explained the conditions for receiving of this benefit/ assistance and explained what the client's obligations means and the reason for them. The client has indicated that he/ she understands and accepts responsibility to provide true and complete information and to advise immediately of any changes in circumstances. All questions have been completed.

Name (print) _____ Signature _____ date _____

Home visit completed:

_____

_____

Additional information:

_____

_____

_____

_____

_____

_____

_____

Recommendation:

_____

_____

_____

(Outer Islands/ Rarotonga)

Application received by: _____

Dates

Application received: _____
Supporting documents : _____
Supplementary documents: _____
Referred to Main Office _____
O/Island Application No. _____
Head Office Application No. _____

(Rarotonga ONLY)

Application received by: _____

Dates

Pay period: _____
Payment amount: _____
Other payment: _____
Payment amount: _____
Addition Voucher No. _____
Main Vchr from: _____

FOR COMMITEE

Decision: _____

_____

Meeting held:

_____

Name (print) _____ Signature _____ date _____

CLIENTS OBLIGATIONS

OFFICE COPY

Please read this statement carefully and sign.

I must tell Social Welfare immediately if:

- I intend to TRAVEL OVERSEAS, whether for holiday or permanently
- My personal details change (such as name, address or bank account)
- I am granted an overseas benefit payment
- My living arrangement and circumstances changes.

I understand that:

- if I have made a false statement ***or***
- if I have failed to answer all the questions in full ***or***
- If I do not tell Social Welfare about changes that it might affect my entitlement or rate.

Then:

- The benefit/ assistance may be reviewed and cancelled ***and***
- I may have to pay back the total amount of any overpayment that I have received ***and***
- I may be prosecuted and fined

My obligations have been explained to me and I understand my responsibilities

Name: _____ Signature: _____ Date: _____

Witnessed by: _____

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CAREGIVERS MEDICAL SUPPORT FORM

Supported Persons Personal Details (the person who will be receiving care & attention)

First Name: _____Surname or Family Name: _____
Are you known by any other name NO YES (please give details below)
Other name/s: _____
_____

Date of Birth:_____ Gender: ____ Village:_____ Island: _____

Contact Details Telephone/ mble: _____ Fax: _____
Email: _____

Carers Personal Details (the person who will be providing care & attention to a supported Person)

First Name: _____Surname or Family Name: _____
Are you known by any other name NO YES (please give details below)
Other name/s: _____
_____

Date of Birth:_____ Gender: ____ Village:_____ Island: _____

Contact Details Telephone/ mble: _____ Fax: _____
Email: _____

Medical Details: *(this section will be filled out by a medical practioner)*

Who do you consider best placed to provide this information?

☐ Yourself ☐Second Opinion

Other :

Are you the Supported Persons usual medical practioner?
☐ No ☐ Yes

When did you last see the supported person? (Including today)
Date last seen: ☐ Never

When is the next scheduled appointment? _____

Please indicate what information this assessment is based on:

_____
_____
_____

What are the supported person's main diagnoses? (Please list the diagnoses in order of their impact starting with the most significant.)

_____
_____
_____
_____
_____

Indicate the main factors that determine the supported person's need for care and attention:

TYPE:	**DESCRIPTION**
PHYSIOLOGICAL/ HEALTH RELATED	☐ **Physical limitations** ☐ **Psychiatric/Psychological condition** ☐**Cognitive/neurological condition** ☐**Sensory Impairment** ☐**Undergoing current treatment** ☐**frequent hospitalization/treatment demands** ☐**Terminal illness** ☐**High levels of Physical support** ☐ **mobility restrictions** ☐ **Chronic pain**
SAFETY	☐ **Respiratory Support** ☐ **Risk to life/ life threatening condition** ☐**Fall risk** ☐**Home safety/security** ☐ **Wandering**
PERSONAL CARE/ HOUSEHOLD MANAGEMENT	☐ **Hygiene/grooming – including dressing & showering or bathing** ☐ **Toileting/continence** ☐**Eating/Drinking** ☐**Medication** ☐**Meal Preparation** ☐**Shopping** ☐**Housework/Laundry** ☐**Finances**

MEMORY, COGNITION AND BEHAVIOUR OTHER (Please Specifiy):	**☐ Memory Loss** **☐ Poor orientation to surroundings** **☐Delusions/hallucinations** **☐Mood/anxiety** **☐Inappropriate social behavior** **☐Limited insight**

Please comment on how these factors impact on the supported person's need for care and attention:

_____
_____
_____
_____

Does the supported person require full time care and attention?

☐NO ☐YES

Is the need for care and attention time limited or permanent?

☐ Time limited (Please specify the expected duration)

_____
_____

☐ Permanent

Medical Practioners / Nurse Practioners :

Name: _____ Family name or surname: _____
Island: _____ Village: _____

Contact Details:
Telephone/mble:_____ Fax:_____ Email:_____
Post Address:_____

Medical /Nurse Practioners Signature: _____

Date certificate completed: _____