Heritage Area Agency on Aging

FY23 CONSUMER INTAKE FORM
Home & Community Based Services

Reset Form ☐

THIS SECTION TO BE COMPLETED BY PROVIDER

Provider Name: Aging Services **Staff :** _____ **New Consumer?** Yes ■ No ☐

Service Received: ☐ Adult Day ☐ Assisted Transportation ☑ Chore ☐ Transportation

The service you are receiving is paid for entirely or partially by funds from the Older Americans Act and the State of Iowa. Your responses on this form are confidential. The Department on Aging uses this information to comply with reporting requirements and to research the needs of older Iowans, we thank you for providing us with this information.

Today's Date:	**Preferred Phone:**
First Name:	**Last Name:** MI:
Date of Birth: Age:	**Email:**

Address: **City:** **St:** **Zip:** **County:**

Gender: ☐ Female ☐ Male ☐ Other **Primary Language:** ☐ English ☐ Other

Select the racial categories that apply to you:

☐ White ☐ Asian ☐ African American/Black ☐ American Indian/Alaskan Native

☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____

Are you Hispanic or Latino? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

If YES is your annual household income more than $13, 590? ☐ Yes ☐ No

If NO is your annual household income more than:

If 2 people, is your annual household income more than $18, 310? ☐ Yes ☐ No

If 3 people, is your annual household income more than $23,030? ☐ Yes ☐ No

If 4 people, is your annual household income more than $27,750? ☐ Yes ☐ No

If 5 people, is your annual household income more than $32,470? ☐ Yes ☐ No

If 6 or more people, is your annual household income more than $37, 190? ☐ Yes ☐ No

Are you interested in learning about additional services?

☐ No ☐ Meals ☐ Transportation

☐ Nutrition Counseling ☐ Legal Assistance ☐ Caregiver Support

☐ Options to stay at home ☐ Options to return to home ☐ Health and Wellness Classes

☐ Chore ☐ Other _____

Heritage
Area Agency on Aging

FY23 CONSUMER INTAKE FORM
Home & Community Based Services

Consumer Name: _____

HELP US SERVE YOU BETTER BY ANSWERING THE FOLLOWING QUESTIONS.

Do you need help with the following?	I don't need help	I need help sometimes	I always need help	Activity does not occur
Shopping?	☐	☐	☐	☐
Managing Medications?	☐	☐	☐	☐
Preparing Meals?	☐	☐	☐	☐
Using transportation or a car?	☐	☐	☐	☐
Managing your money/ paying bills?	☐	☐	☐	☐
Cleaning your house?	☐	☐	☐	☐
Sorting, loading, washing, drying, and folding laundry?	☐	☐	☐	☐
Using the telephone?	☐	☐	☐	☐

During the past 7 days did you need help with:	I didn't need help	I needed help sometimes	I always needed help
Bathing or showering?	☐	☐	☐
Getting dressed?	☐	☐	☐
Getting out of or into a bed or chair?	☐	☐	☐
Eating?	☐	☐	☐
Getting to the toilet on time? (able to control bladder/bowels?)	☐	☐	☐
Using the toilet?	☐	☐	☐

UnityPoint Health
AbbeHealth Services

Aging Services
HOME REPAIR & ACCESSIBILITY
Application – FY23

Name: _____ Date _____

Address _____

Mailing Address (if different): _____

Preferred Phone #: _____ Birthdate: _____

Email: _____

Do you own your home? YES NO Is this a mobile home? YES NO

Do you own additional property? YES NO Details _____

Brief Health History – Please check all applicable boxes –

☐Visual Impairment ☐Hearing Impairment ☐Confusion/Forgetfulness ☐Wheelchair ☐Walker

Do you have any other health issues we should be aware of? _____

_____

Please list other any adults who live with you

Name _____ Relation_____

Name _____ Relation_____

Current Resources Information

Do you have health insurance and/or a primary care provider (PCP)? YES NO

Do you currently receive Medicaid and/or Elderly Waiver benefits? YES NO

If so, Medicaid State ID#: _____

Who is your Managed Care Organization? AmeriGroup IA Total Care Other/Unsure

Case Manager: _____

Aging Services, Inc. and its programs will consider this application without regard to race, color, creed, religion, national origin, sex, sexual orientation, disability, age, marital status, public assistance status, genetic or family medical history, or any other protected classification under local, State or Federal law. By signing below, I agree that this application is complete and accurate to the best of my knowledge. I authorize the investigation of all statements contained in this application and supporting documents, and I release all parties from any liability arising from such investigation. Continuation of all programs depends on availability of funding sources.

_____ _____

Applicant Signature **Date**

UnityPoint Health
AbbeHealth Services

Aging Services
HOME REPAIR & ACCESSIBILITY
Home Liability Waiver

The goal of the Aging Services Home Repair & Accessibility program is to help older adults remain safely in their home. We make every attempt to ensure the safety of our participants and will attempt to fix original home repair requests to the best of our ability. Unfortunately, in our experience, we have found that it may be difficult to find a contractor that has the tools necessary to complete home repairs satisfactorily due to the age, materials, and/or structure of some homes.

By signing this waiver, I _____,
Homeowner's Name

of _____,
Street Address, City, State, Zip Code

release Aging Services, its employees, and volunteers, from any and all liability arising out of any services performed for me through the Home Accessibility & Repair program, including, but not limited to, complications related to unusual materials or prefabricated structures, injuries to me or other persons and damages to my property, equipment, and/or belongings. I understand that Aging Services will attempt to fix the original home repair request to the best of their ability. However, Aging Services will not be able to repair any secondary damages that may have occurred as a result of the initial problem.

_____ _____
Participant Signature Date

_____ _____
Aging Services Representative Date

UnityPoint Health
AbbeHealth Services

Aging Services
HOME REPAIR & ACCESSIBILITY
Authorization for Release of Information

Authorization for Release of Information

Client

Address City State Zip

I hereby authorize Aging Services, Inc. and the Home Repair & Accessibility Program to release to and exchange relevant information with the following:

- Service Providers and Volunteers

This information will be used to coordinate services with providers and/or program volunteers, communicate with partner agencies, contact authorized resources, and otherwise ensure proper service completion according to the Aging Services Home Repair & Accessibility program guidelines.

By signing below, I agree that this release begins on the date signed and shall continue to be in effect until September 30, 2023. I am aware that I may revoke this contract at any time by putting my request in writing and turning it in to the Aging Services Home Repair & Accessibility Program.

Signature Date

Aging Services Program Coordinator Date

Prohibition on Re-disclosure
This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (41 D.F.R. Part 2) and state requirements (Iowa Code ch. 228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulation. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

UnityPoint Health
AbbeHealth Services

Aging Services
HOME REPAIR & ACCESSIBILITY
Authorization for Release of Information

Name _____

Address _____ City _____ State _____ Zip _____

I hereby authorize the Aging Services Home Repair & Accessibility Program to release to and exchange relevant information with the following agencies:

Emergency or Family Contact (please print)		
First Name	Last Name	
Address		
City	State	Zip
Phone	Relationship	

If you would like to authorize any additional individuals including friends, family members, doctors, or others, please list them below:

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

This information will be used communicate with and report relevant information as needed to the above listed emergency or family contact.

By signing below, I agree that this release begins on the date signed and shall continue to be in effect through September 30, 2023. I am aware that I may revoke this contract at any time by putting my request in writing and turning it in to the Aging Services Home Repair & Accessibility Program.

Signature _____ Date _____

Aging Services Program Coordinator _____ Date _____

Prohibition on Re-disclosure

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UnityPoint Health
AbbeHealth Services

Aging Services
HOME REPAIR & ACCESSIBILITY
Snow Removal Application & Agreement

Client Information

Name: _____

Home Address: _____

Preferred Phone #: _____

E-Mail address_____

*Please check **ONE** of the following packages which best fits your snow removal needs:*

☐ **Mobile Home Package:** Snow removal from driveway, path to the door and ramp or partial entry way.

☐ **Standard Lot Home:** Snow removal from driveway, path to the door, 1 sidewalk, and ramp or partial entry way.

☐ **Corner Lot Home:** Snow removal from driveway, path to the door, 2 sidewalks, and ramp or partial entry way.

☐ **Check this box only if you do not have a sidewalk**

*Circle **one** from each category:*

1. **My driveway size:** One car Two Cars I don't have a driveway
2. **I need a path to my door (choose one only):** In the front In the Back On the side
3. **I have a ramp:** Yes or No
4. **I need a path for trash (choose only one):** In the front In the Back On the side

Acceptance Statement:
I agree to all conditions of the program as described in the snow removal agreement.

1. I am requesting Aging Services Snow Removal Program service for the 2022-2023 snow removal season.
2. I understand I can cancel this service at any time by contacting the Aging Services Home Repair & Accessibility staff, and that by doing so, I am not disqualified from eligibility for other services.
3. I am aware that non-compliance with program policy, procedure, and restrictions under this agreement may be grounds for removal from the Home Repair & Accessibility Program. Depending on the issue, I may or may not receive a written advance warning.

Aging Services, Inc. and its programs will consider this application without regard to race, color, creed, religion, national origin, sex, sexual orientation, disability, age, marital status, public assistance status, genetic or family medical history, or any other protected classification under local, State or Federal law. By signing below, I agree that this application is complete and accurate to the best of my knowledge. I authorize the investigation of all statements contained in this application and supporting documents, and I release all parties from any liability arising from such investigation. I understand that services I receive may include a Sliding Contribution Scale, and I agree to pay my share based on this agreement. Continuation of all programs depends on availability of funding sources.
*Heritage Disclaimer: Any services/projects funded through the Heritage Area Agency on Aging are not subject to the client contribution scale.

_____ _____
Applicant Signature **Date**

UnityPoint Health
AbbeHealth Services

Aging Services
HOME REPAIR & ACCESSIBILITY
Snow Removal Application & Agreement

Snow Removal Program - Service Description:

- Service begins November 15th and ends March 15th.
- Snow will be cleared when **it has reached 2 inches on average across the area *and* the temperature is** expected to stay below freezing for the next 24-48 hours.
- Removal begins after the snow has stopped or if there is a long break between snow showers.
- The contractors have 24 hours to remove the snow after we contact them.
- Service may be completed anytime, day or night.
- Snow is only removed on the driveway, city sidewalks, to the alley for trash, off ramps, and in front of your door to allow you to walk out to the street or driveway. No exceptions.

We are unable to provide customized services, including, but not limited to:

- Paths and/or areas cleared for pets
- Removal of snow from your *entire* porch, deck, or patio. Only enough space for entry and exit.
- Paths for meter readers or mail carriers other than city walks
- We cannot remove ice or packed down snow at any time, even if it has accumulated.
- Removal of snow from vehicles
- Removal of snow from eaves and/or overhangs
- Salt or sand distribution
- We cannot return to remove any snow from a previously cleared area, including snow a snowplow has pushed in or if the wind has blown the snow back in.
- We are not responsible for accidents or damages. Please completely clear yard ornaments, planters, etc. from areas where snow removal will occur.
- Contractors may not be able to plow your driveway if there is a car in it. If your car is in the driveway, contractors will plow as much as they can behind the car but will not be able to clear all snow. We do not want the contractors accidentally damaging any vehicles so they must maintain a certain amount of space around the vehicle. We allow them to determine what is safe.
- We cannot plow a driveway if the contractor cannot get into it. Make sure adequate room is provided. This may require talking to neighbors.

Be sure you understand this program before signing up for it.

- By participating in our program, you agree to follow the terms of the snow agreement.
- If it does not meet your needs, we can provide you with a list of service providers.
- If you have questions or concerns, please call our office.
- Requests and demands for excluded services can result in termination from the program.

Sole Snow Removal Service Provider:

You may not hire or use another person to remove your snow unless:

- The snow is under 2 inches after the snow has stopped
- We are not planning to remove it.

Canceling Service:

- You cannot cancel individual rounds of snow.
- You can terminate your participation in the snow removal program at any time.

UnityPoint Health
AbbeHealth Services

Aging Services
HOME REPAIR & ACCESSIBILITY
Financial Assistance Application

Date: _____ Client Name: _____

Is someone else ***FINANCIALLY RESPONSIBLE*** for your bills or do you have a financial power of attorney, conservator, rep payee, or guardian? YES NO *** Include a copy with this application ***
Name _____ Phone _____

ASSETS for all individuals in the home

	Applicant	Spouse	Other
Current total in Checking Account			
Current total in Savings Account			
Current total in Stocks/Bonds/CDs/IRAs			
Other current assets (life ins., etc.)			
Total Assets (if over $10,000, 2% is income)			

MONTHLY INCOME for all individuals in the home

	Applicant	Spouse	Other
Social Security			
Wages/Unemployment			
Dividends/Interest Income			
Railroad/Veteran's Benefits/Income			
Pension Income			
Income from Trust/Family/Child Support			
Other			
Total Income			

COMBINED INCOME AND ASSETS $ _____

Aging Services may require verification of income and/or assets depending on the funding source used.

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_____ _____
Applicant Signature **Date**

AGING SERVICES STAFF USE ONLY
ACCORDING TO THE AGING SERVICES SLIDING CONTRIBUTION SCALE, THIS CLIENT CONTRIBUTES: _____%
Date client notified _____ Aging Services staff signature _____