UnityPoint Health
AbbeHealth Services

Aging Services

1725 O Ave NW
Cedar Rapids, IA 52405
Phone: (319) 398-3647
Fax: (319) 398-3954
unitypoint.org/agingservices

March 1, 2024

Hello!

The Aging Services Home Accessibility & Repair Program is pleased to offer lawn mowing service for older adults in our community again this year. Information regarding this program is included with this mailing. Please review the program information in full.

If you accept the guidelines of the Aging Services Lawn Mowing program and wish to apply for this service, please complete all the enclosed forms listed below and return them in the envelope provided by **April 1, 2024**:

- Consumer Intake Form
- 2024 Lawn Application
- Home Repair & Accessibility program application
- Home Liability Waiver form
- All releases of information
- Financial Assistance Application ***and*** a copy of recent monthly bank statement – including all pages, with your name and address (***this is required if you would like to apply for no cost lawn services*** – *if it is not included, you will be offered services at a cost through private pay)*

It is important that your paperwork be turned in as soon as possible for review. **All paperwork must be submitted to our office by 4/1/24 to apply for no cost lawn mowing service.** Missing paperwork will slow the processing of your application or may result in your application being denied. If you have any questions, or need assistance completing these forms, please call (319) 398-3647.

Please note, funding for this program is not guaranteed and is dependent upon a number of factors. All applicants will receive a notification letter on whether or not your application has been approved, after the deadline posted above. Applicants who are approved for services will receive a schedule of projected mow dates.

Thank you again for your interest in the Aging Services Lawn Mowing Program!

Heritage
Area Agency on Aging

FY24 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 ☐ Transportation
☑ Chore ☐ Material Aid: Consumable Supplies (Includes: Essentials/Produce Pantry)

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

Live alone: Is annual household income more than $14,580?	☐ Yes	☐ No
2 person household: Is annual household income more than $19,720?	☐ Yes	☐ No
3 person household: Is annual household income more than $24,860?	☐ Yes	☐ No
4 person household: Is annual household income more than $30,000?	☐ Yes	☐ No
5 person household: Is annual household income more than $35,140?	☐ Yes	☐ No
6 person household: Is annual household income more than $40,280?	☐ Yes	☐ No

Are you in need of additional services? If yes, please select options below:

☐ No ☐ Yes	☐ 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

Consumer Name: _____ _____

Help us serve you better by answering the following questions.

Do you need help with:	I don't need help	I need help sometimes	I always need help	Activity does not occur
Shopping?	☐	☐	☐	☐
Managing medications?	☐	☐	☐	☐
Preparing meals?	☐	☐	☐	☐
Using transportation/ 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:	I don't need help	I need help sometimes	I always need help
Bathing or showering?	☐	☐	☐
Getting dressed?	☐	☐	☐
Getting out of or into a bed or chair?	☐	☐	☐
Eating?	☐	☐	☐
Getting to toilet on time? (able to control bladder/bowels?)	☐	☐	☐
Using the toilet?	☐	☐	☐

UnityPoint Health
AbbeHealth Services

Aging Services
HOME ACCESSIBILITY & REPAIR
Lawn Mowing Application & Agreement - 2024

Client Information

Name _____ Date of Birth _____

Address _____

City _____ Zip Code _____ Preferred Phone _____

Current Resources Information

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

If so, Medicaid State ID#: _____

Managed Care Organization: Wellpoint/Amerigroup IA Total Care Molina Other

Case Manager's Name: _____

Please list any adults who live with you:

Name _____ Relation _____

Name _____ Relation _____

Property Information:

1. **Do you own the home?** Yes No
2. **Lot size** (circle one): Standard Corner Mobile Home
3. **Please include any notes about property you would like us to know (fenced areas, flower beds, etc.):**

_____

_____

Acceptance Statement:

By signing below, I agree that I received a copy of the Lawn Mowing Program agreement and I agree to all conditions of the program as described in the Lawn Mowing Program agreement.

1. I am requesting Aging Services Lawn Mowing Program service for the 2024 lawn mowing 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 ACCESSIBILITY & REPAIR
Lawn Mowing Application & Agreement - 2024

Lawn Mowing Program – Service Description:

- To serve the greatest number of seniors in our community, Aging Services will provide basic lawn mowing service to each participant.
- Service generally begins in May and ends in September. This may be subject to change based on weather and funding availability.
- This service aims to keep the grass within the City of Marion's requirement of 8 inches or shorter and the City of Cedar Rapids' requirement of 12 inches or shorter.
- Mowing is every 7 to 10 days or so, weather permitting.
- Service will not be provided if the weather has been dry and the majority of participants do not need service.
- Lawn Contractors can mow the day before, the day of, or the day after the scheduled mowing date.

Aging Services is unable to provide customized services, including, but not limited to:

- Bagging of lawn clippings
- Weed treatments and trimming
- Deck height adjustments to cut grass shorter or longer to preference
- Service to hazardous, inaccessible, or debris laden ground
- Removal of pet waste – No service will be provided if pet waste is deemed excessive.
- We do not require that lawn contractors utilize a push mower – Due to the vast number of clients the lawn contractors serve and the discounted services they provide for Aging Services, we will not be able to accommodate requests/demands for push mowing services.
- We are not responsible for accidents or damages. Please ensure that your yard is clear of items before mowers arrive. Items left out could be a hazard to your property and the contractors' equipment.

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

- By participating in our program, you agree to follow the terms of the lawn 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 Lawn Mowing Service Provider:

- While under agreement with Aging Services, you may not hire or use another person to mow your lawn.
- In the event that our contractor finds the lawn has already been mowed, a written warning will be sent to the client.
- Non-compliance with program policy may result in removal from lawn mowing services.

Canceling Service:

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

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Common Home Repair Program Projects

We receive many questions about the projects we perform. Generally, we like to focus on basic health and safety issues that can be resolved under $300. We attempt to do this with the least expensive resolution. Sometimes this means that the finished project will not look as nice as a client desires, but the problem is solved.

Please remember that we are not able to assist in emergency situations or with appliances. For example, if your faucet is shooting water out of the top, we will not be able to send someone out immediately to help. We highly recommend learning how to turn off your water should that occur.

There is a waiting list sometimes. We also prioritize projects because some things are more dangerous if left unattended to over time.

Here are some examples of past projects we have accepted.

- Grab bar/handrail installation in showers or stairs
- Drain clogs in bathroom or kitchen
- Pipe leaks in bathroom or kitchen
- Running toilets
- Dripping faucets
- Electrical outlets that do not work
- Exposed wiring
- Flickering lights
- Leaking toilet
- Minor holes in floor
- Patching a leaking roof
- Exterior doors that will not close and lock (not screen or storm doors)
- Exterior door that have holes in them. (not screen or storm doors)
- Fall leaf raking (volunteers only)
- Snow removal and lawn mowing (requires separate seasonal application sent to you automatically)

You are always welcome to call us and ask if we can do a project. Sometimes, if there is a volunteer who specializes in a particular trade or if there is extra funding, we can do other larger projects.

UnityPoint Health
AbbeHealth Services

Aging Services
HOME REPAIR & ACCESSIBILITY
Application – FY24

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 Molina 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
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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

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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, 2024. 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
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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, 2024. 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 _____

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Aging Services
HOME REPAIR & ACCESSIBILITY
Authorization for Release of Information – Case Management

ELDERLY WAIVER CLIENTS ONLY

If you are not a state elderly waiver client, please ignore this page.

Authorization for Release of Information

Client

Address City State Zip

Case Manager Insurance Company Phone Number

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

- Case Manager at Managed Care Organization

This information will be used to contact authorized resources, and otherwise ensure proper implementation of services 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, 2024. 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.

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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.

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**

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