UnityPoint Health
AbbeHealth Services

Aging Services

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

Thank you for your interest in the Aging Services Home Accessibility & Repair Program! We look forward to working with you to meet your small home repair needs.

The Home Accessibility & Repair Program assists with small home repairs to help maintain and/or improve home safety and function. On the back of this letter, you will find more information about our program.

Included with this letter is our required application. Please review the enclosed items carefully and fill out all forms completely and sign where needed. The application and other forms are a requirement of the Home Accessibility & Repair Program and are necessary based on the guidelines of the agencies providing funding for our services.

Financial assistance is available for those who would like assistance in covering all or part of any potential projects and lawn mowing or snow removal services. **To be considered for financial assistance, you MUST complete the financial assistance application for *all members of the household*. To verify eligibility, we must have complete copies of bank statements for all members of the household (checking, savings, 401K, Stocks, Bonds, etc.).** You are welcome to block out account numbers, however; please do not block out any other information.

Once we have received your completed paperwork, we will confirm program eligibility and contact you regarding your specific request.

If you have any questions or need assistance completing the enclosed forms, please call us at 319-398-3647.

Sincerely,

The Aging Services Home Accessibility & Repair Team

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Common Home Repair Program Projects

We receive many questions about the projects we assist with. Generally, we like to focus on basic health & safety issues that can be resolved under $300. We attempt to do this with he 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. We are also not able to assist with repairing or replacing appliances including but not limited to garbage disposals, stoves, ovens, microwaves, washers, dryers, and window air conditioners.

We typically have a waiting list and projects are prioritized for project requests considered dangerous if left unattended to over time.

Here are some examples of common projects we have accepted in the past:

- Drain clogs in kitchen or bathroom
- Pipe leaks in kitchen or bathroom
- Running toilets
- Leaking toilet
- Dripping faucets
- Electrical outlets that do not work
- Exterior door that will not close and lock (not screen or storm doors)
- Exterior door that have holes in them (not screen or storm door)
- Fall leaf raking (completed by volunteers only)
- Snow Removal (requires separate seasonal application sent to you automatically)
- 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 may be able to do other larger projects.

UnityPoint Health
AbbeHealth Services

Aging Services
HOME REPAIR & ACCESSIBILITY
Application – FY25

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? Wellpoint IA Total Care Molina

Case Manager Name: _____Case Manager's Phone:_____

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
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 _____

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

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UnityPoint Health
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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, 2025. 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, 2025. 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 – 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, 2025. 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.

Heritage
Area Agency on Aging

FY25 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. HHS Division of Aging and Disability Services uses this information to comply with reporting requirements and to research the needs of older Iowans.

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 $15,060?	☐ Yes	☐ No
2 person household: Is annual household income more than $20,440?	☐ Yes	☐ No
3 person household: Is annual household income more than $25,820?	☐ Yes	☐ No
4 person household: Is annual household income more than $31,200?	☐ Yes	☐ No
5 person household: Is annual household income more than $36,580?	☐ Yes	☐ No
6 person household: Is annual household income more than $41,960?	☐ Yes	☐ No

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

☐ 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

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
Cleaning your house?	☐	☐	☐	☐
Managing medications?	☐	☐	☐	☐
Managing your money/ paying bills?	☐	☐	☐	☐
Preparing meals?	☐	☐	☐	☐
Shopping?	☐	☐	☐	☐
Sorting, loading, washing, drying and folding laundry?	☐	☐	☐	☐
Using the telephone?	☐	☐	☐	☐
Using transportation/car?	☐	☐	☐	☐

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?	☐	☐	☐
Eating?	☐	☐	☐
Getting dressed?	☐	☐	☐
Getting out of or into a bed or chair?	☐	☐	☐
Getting to toilet on time? (able to control bladder/bowels?)	☐	☐	☐
Using the toilet?	☐	☐	☐