

February 5<sup>th</sup>, 2025

Hello,

The Aging Services Home Accessibility & Repair Program is pleased to offer lawn mowing service for older adults in our community again this year. This basic lawn mowing service is meant to serve low-income older adults or adults who may not be physically capable of completing lawn mowing themselves. It is not a replacement for landscaping or gardening services.

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 **March 21<sup>st</sup>, 2025**.

- Heritage Consumer Intake Form
- 2025 Lawn Application
- Home Repair & Accessibility program application including:
  - 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. In addition, you will not receive free-to-low-cost home repair services without financial information and will need to pay full price for all repairs.***)

It is important that your paperwork be turned in as soon as possible for review. **All paperwork must be submitted to our office by 3/21/25 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. On a case-by-case basis, if we receive your application for lawn mowing after the deadline, we may offer private pay lawn mowing.

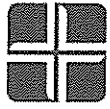
If you have any questions, or need assistance completing these forms, please call (319) 398-3647.

**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 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!

Best,

**The Aging Services Staff**



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 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: \_\_\_\_\_

Do you have the Elderly Waiver through Medicaid?: YES NO

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**



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



**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.

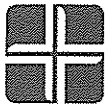
By signing below, I agree that this release begins on the date signed and shall continue to be in effect until September 30, 2025. I am aware that I may revoke this contract at any time by putting my request in writing and turning it in to the Aging Services Home Repair & Accessibility Program.

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.



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.

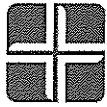
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**ELDERLY WAIVER CLIENTS ONLY**

**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.

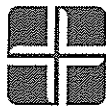
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Signature \_\_\_\_\_ Date \_\_\_\_\_

Aging Services Program Coordinator \_\_\_\_\_ Date \_\_\_\_\_

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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 \_\_\_\_\_

<b>ASSETS for all individuals in the home</b>			
	<b>Applicant</b>	<b>Spouse</b>	<b>Other</b>
Current total in Checking Account	_____	_____	_____
Current total in Savings Account	_____	_____	_____
Current total in Stocks/Bonds/CDs/IRAs	_____	_____	_____
Other current assets (life ins., etc.)	_____	_____	_____
<b>Total Assets</b> (if over \$10,000, 2% is income)	_____	_____	_____

<b>MONTHLY INCOME for all individuals in the home</b>			
	<b>Applicant</b>	<b>Spouse</b>	<b>Other</b>
Social Security	_____	_____	_____
Wages/Unemployment	_____	_____	_____
Dividends/Interest Income	_____	_____	_____
Railroad/Veteran's Benefits/Income	_____	_____	_____
Pension Income	_____	_____	_____
Income from Trust/Family/Child Support	_____	_____	_____
Other	_____	_____	_____
<b>Total Income</b>	_____	_____	_____
<b>COMBINED INCOME AND ASSETS</b>		\$ _____	

*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**

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



**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

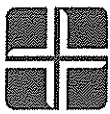
Are you in need of additional services? If yes, please select options below:

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 \_\_\_\_\_

*Help us serve you better by answering the following questions.*

<b>Do you need help with:</b>	<b>I don't need help</b>	<b>I need help sometimes</b>	<b>I always need help</b>	<b>Activity does not occur</b>
Cleaning your house?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing your money/ paying bills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sorting, loading, washing, drying and folding laundry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the telephone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using transportation/car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>During the past 7 days did you need help:</b>	<b>I don't need help</b>	<b>I need help sometimes</b>	<b>I always need help</b>
Bathing or showering?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting dressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting out of or into a bed or chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting to toilet on time? (able to control bladder/bowels?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**Client Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_ Preferred Phone \_\_\_\_\_

**Current Resources Information**

Do you currently receive Medicaid benefits? YES NO

If so, Medicaid State ID#: \_\_\_\_\_

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

Case Manager's Name: \_\_\_\_\_

Do you have the Elderly Waiver? YES NO

**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.

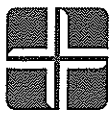
1. I am requesting Aging Services Lawn Mowing Program service for the 2025 lawn mowing season.
2. I understand I can cancel this service at any time by contacting the Aging Services Home Repair & Accessibility staff, and that by doing so, I am not disqualified from eligibility for other services.
3. 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 \_\_\_\_\_



**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.
- On a regular basis, Aging Services will update the Chore Line with information concerning lawn mowing at (319) 892-8218.

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

- Our services are designed to provide basic lawn mowing to low-income older adults that will keep you within City requirements.
  - We cannot provide additional lawn, landscaping or specialized services at this time
- 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.
- Removal of pet waste – No service will be provided if pet waste is deemed excessive. Please be considerate of our contractor's equipment and time by removing pet waste ahead of mowing.

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

- Bagging of lawn clippings
- Sweeping or cleaning of any lawn particles that may drift onto sidewalks, patios, driveways, and ramps
- Weed treatments and trimming
- Landscaping
- Gardening services
- Deck height adjustments to cut grass shorter or longer to preference; contractors will cut grass to be within City requirements
- Service to hazardous, inaccessible, or debris laden ground



**Sole Lawn Mowing Service Provider:**

- While under agreement with Aging Services, you may not hire or use another person to mow your lawn.
- If our contractor finds the lawn has already been mowed or Aging Services is informed that your lawn has been mowed by another contractor, a written warning will be sent to the client.
  - Please note: we will not penalize you if a friendly neighbor or family member mows your lawn without your knowledge (unless it becomes a recurring issue). We understand that lawns are friendly and often like to help their neighbors! If this happens, please notify us.
- Non-compliance with program policy may result in removal from lawn mowing services.

**Canceling Service and Non-Compliant Termination:**

- You cannot cancel individual rounds of lawn mowing.
- You can terminate your participation in the lawn mowing program at any time.
- Non-compliant termination: if you are non-compliant with the program rules, you may be discharged from the program after a written warning is issued.
  - Harassment and bullying of either our contractors, program coordinator, or Aging Services staff will result in termination from the program.
  - Non-compliant termination is a last resort; our program coordinator and staff are always willing to work with you to solve problems, and mediate difficult situations.

## Cedar Rapids Area Lawn Mowing Services

- True Home Services (319) 481-8783
- Darnell Construction (319) 378-4775
- Slaymaker Landscaping: (319) 389-1526
- Naturescape: (319) 366-0040
- Progressive Concrete: (319) 329-2640
- Powers Plowing: (319) 241-2004
- Classic Lawn Care: (319) 363-2332ben
- Behrends Lawn Care: (319) 640-3616
- Greg's Lawn & Landscaping: (319) 393-0101 or (319) 337-5296
- Yards by Wes: (319) 804-5733
- Bender's Lawn Care: (319) 560-0771
- Elite Lawn & Landscaping: (319) 447-6091
- Clean Cut Property Services: (319) 377-8873
- Maker Enterprises: (319) 350-0803
- Starks Complete Lawncare: (319) 396-8323
- Aaron's Lawn Care & Landscaping: (319) 447-9301
- Country Club Lawn Care & Landscaping: (319) 929-1976
- Possibilities Unlimited: (319) 310-2195
- Hewitt Lawn Care & Snow Removal: (319) 531-6395

*Disclaimer: The information provided is for informational use only. Aging Services does not specifically recommend, endorse, or sponsor any of the businesses or individuals listed above. This information was gathered as a reference and Aging Services is not liable for any problems that may arise upon use of any of the businesses or individuals listed above.*