lavaaa
advocacy | action | answers on aging

Lower Arkansas Valley
Area Agency on Aging

LAVAAA Material Aid Services Application Packet

Please choose one:

- ☐ DENTAL/DENTURES
- ☐ GLASSES
- ☐ HEALTH EQUIPMENT
- ☐ HEARING AIDS
- ☐ LOW VISION*

*If your vision cannot be corrected to normal levels with regular glasses or contacts, please check the **"LOW VISION"** option to request **VISION AIDS** (magnifiers, giant print items, talking items, etc.).

Client Information

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____

County where you live: _____

Provider Information for Service Requested
(Dental, Glasses, Health Equipment, Hearing) if known:

Doctor or Facility Name: _____

Address: _____ **City:** _____

Service Description and Cost: _____

OFFICE USE ONLY
DATE COMPLETED APPLICATION (including REQUIRED ITEMS) was RECEIVED: _____

REQUIRED ITEMS:

DENTAL (including **DENTURES)** applicants MUST answer the following questions:

Are you eligible for Medicaid dental benefits? ☐ Yes ☐ No ☐ Unsure

If **YES or UNSURE**, please contact DentaQuest at 1-855-225-1729 or www.dentaquest.com before applying.

Is your annual income less than $36,450 (household of 1) or $49,300 (household of 2)?

☐ Yes ☐ No

If **YES**, we will help you connect with a Colorado Dental Health Care Program for Low Income Seniors provider.

Have you reached your Medicaid dental benefit yearly limit or, has your dental provider reached their Low Income Senior Dental Program yearly limit?

☐ Yes ☐ No ☐ Unsure

If **YES or UNSURE**, please speak with LAVAAA staff.

DENTAL applications MUST include a **TREATMENT PLAN and ESTIMATE** from your dentist.

GLASSES applications MUST include an **ESTIMATE** from your glasses provider showing the lenses and frames you have selected.

HEARING applicants MUST answer the following questions:

Do you currently have hearing aids? ☐ Yes ☐ No

If yes, how old are your hearing aids? ☐ Less than 5 years ☐ More than 5 years

If yes, are your current hearing aids repairable? ☐ Yes ☐ No

HEARING applications MUST include a **HEARING TEST and ESTIMATE** from an audiologist or hearing provider.

HEALTH EQUIPMENT applications MUST state the **ITEM/s requested*** and MUST include a **STATEMENT OF NEED or BENEFIT** from a medical provider. **Contact us with questions if uncertain.*

VISION AIDS applications for special equipment (magnifiers, giant print items, talking items, etc.) MUST include a statement of your vision impairment or condition (on page 5 of this application packet). A doctor's statement is *NOT* necessary.

*Providers may email or fax the information directly to us or may provide a copy for you to attach to the application. It is **YOUR** responsibility to provide the information, or request that the provider send it to us.* ***Applications that do not include the required items will NOT be processed until the required documents are provided.***

lavaaaa
advocacy | action | answers on aging

Lower Arkansas Valley
Area Agency on Aging

Lower Arkansas Valley Area Agency on Aging
Acknowledgement & Release of Liability

I, _____, am voluntarily participating in the Material Aid program through the Lower Arkansas Valley Area Agency on Aging (LAVAAA). My signature authorizes LAVAAA to verify information provided on the application and authorizes the medical provider to release information to LAVAAA. By signing this form, I verify that the information I have provided is true and correct to the best of my knowledge.

Further, I acknowledge and understand that:

- Services are available **only to those 60 years of age or older**.
- Services are available **only to residents of Region 6 (Baca, Bent, Crowley, Kiowa, Otero, Prowers Counties)**.
- Priority is given to the neediest as specified in the Older Americans Act, and I may be placed on a waitlist for services if funds are unavailable.
- LAVAAA is not responsible for conducting a criminal background check on the service provider.
- LAVAAA will reimburse the service provider directly when services are completed and all terms and conditions are met. *LAVAAA does not reimburse for services that have already been completed and/or paid for.*
- I am selecting the provider of services. LAVAAA is not the employer of record for these services.
- I am responsible for checking if I am eligible for Medicaid, Medicare, and the Colorado HCPF *Colorado Dental Health Care Program for Low Income Seniors* (if applying for dental assistance); and that LAVAAA is the payer of last resort for approved services only.
- I am responsible for developing the Care/Treatment Plan with the service provider, including contacting the service provider if any problems arise and to schedule all appointments.
- I voluntarily assume full responsibility for any risks of loss or personal injury, including death, which may be sustained by me as a result of any medical procedures I may undergo.
- I am required to complete an intake assessment for eligibility determination.
- I may be asked to complete a Consumer Satisfaction Survey.
- I have received a copy of the LAVAAA Voluntary Contribution Policy, Complaint & Grievance Policy, and Waitlist Policy.
- I am responsible for scheduling an appointment within one week of receiving approval for services. **All services must be completed by the date specified on my approval letter.**

Signature: _____ **Date:** _____

Return application to: **LAVAAA**
13 W. 3rd Street, Room 110
La Junta, CO 81050

May be emailed to: Kenneth.shearer@state.co.us

lavaaa
advocacy | action | answers on aging

Lower Arkansas Valley Area Agency on Aging

Provider/Program **Intake and Assessment (SFY 24)**

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. We ask for demographic information to meet requirements from our funders. All your personal information is confidential. Please see the attached FAQs for more information and guidance on filling out this form.

Contact & Demographic Information

First Name: _____ **Middle Name/Initial:** _____

Last Name: _____ **Nickname:** _____

Date of Birth: _____ **Age:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Home Address Line 1: _____

Line 2 (Apt/Lot #): _____ City: _____

Zip: _____ County: _____ State: _____

Mailing Address: ☐ Same as Home Address

If different: Line 1: _____

Line 2 (Apt/Lot #): _____ City: _____

Zip: _____ County: _____ State: _____

Location Comments (additional directions for home or mailing address):

_____

Gender: ☐ Male ☐ Female ☐ Other (optional): _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race, select all that apply:

☐ American Indian or Alaska Native
☐ Asian or Asian American
☐ Black or African American
☐ Race not listed: _____
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White (including Hispanic)

Name: _____ **Date:** _____

Do you live: ☐ Alone ☐ With Others
Number of people in your household (including you)**:** _____

(Please note that income above the amount listed does NOT disqualify you from services.)
If you live alone, is your monthly income: ☐ ABOVE $1,569 ☐ At or BELOW $1,569

If you live with others, is your total household size (including you) and monthly income:
2 People in Household: ☐ ABOVE $2,129 ☐ At or BELOW $2,129
3 People in Household: ☐ ABOVE $2,690 ☐ At or BELOW $2,690
4 People in Household: ☐ ABOVE $3,250 ☐ At or BELOW $3,250

Optional: Monthly Household Income: _____

Marital Status: ☐ Single ☐ Domestic Partner ☐ Married
☐ Divorced ☐ Separated ☐ Widowed

Are you a Veteran? ☐ Yes ☐ No

Communication & Service Needs

Health Insurance (select all that apply):
☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Medicaid Waiver ☐ None
☐ Other: _____

Are you interested in learning about nutrition and a healthy diet? ☐ Yes ☐ No

Would you like to hear about other services? ☐ Yes ☐ No
If yes, how can we contact you? ☐ Email ☐ Mail ☐ Phone
What services are you interested in? ☐ Chore/Homemaker ☐ Respite for Caregivers
☐ Material Aid (Dental, Hearing, Health Equip, Vision/Vision Aids) ☐ Transportation
☐ Other: _____

OFFICE USE ONLY: Referred to: _____
By: _____ Date: _____

Name: _____ **Date:** _____

Nutrition Screening (OPTIONAL)

Determine your nutritional health. If the statement is true for you, check the box in the "Yes" column and add the points in the "Yes Score" column to your total score.

Nutrition Risk Score Questions	Yes	No	Yes Score
1. Do you have an illness or condition that has made you change the kind and/or amount of food you eat?	☐	☐	2
2. Do you eat fewer than 2 meals per day?	☐	☐	3
3. Do you eat few fruits, vegetables, or milk products?	☐	☐	2
4. Do you have 3 or more drinks of beer, liquor, or wine almost every day?	☐	☐	2
5. Do you have tooth or mouth problems that make it hard for you to eat?	☐	☐	2
6. Are there times you do not have enough money to buy the food you need?	☐	☐	4
7. Do you eat alone most of the time?	☐	☐	1
8. Do you take 3 or more different prescribed or over-the-counter drugs a day?	☐	☐	1
9. Without wanting to, have you lost or gained 10 pounds in the last 6 months?	☐	☐	2
10. Are there times you're physically unable to shop, cook, and/or feed yourself?	☐	☐	2
Total Nutrition Risk Score *Total "Yes" Score:*			

Total Nutrition Risk Score: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk – take action! Speak with a qualified health or social service professional about your nutritional health. Providers – if the client is at high nutrition risk, please make a case note and appropriate referral.

Are you interested in receiving nutrition counseling? ☐ Yes ☐ No

Name: _____ **Date:** _____

ADLs and IADLs (OPTIONAL)

For each activity, please mark the level of help you (or the client) needs.

Independent: no help needed
Some human help: needs some assistance, constant supervision not required
Lots of human help: needs assistance and/or supervision to complete most parts of activity

Activities of Daily Living (ADLs)	Independent (no help)	Some Human Help Needed	Lots of Human Help Needed
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Using the Bathroom	☐	☐	☐
Transferring In/Out of Bed/Chair	☐	☐	☐
Walking/Getting Around the House	☐	☐	☐
Eating	☐	☐	☐

Are you receiving assistance with ADLs or IADLs from anyone? ☐ Yes ☐ No

If yes, who is assisting you? _____

Comments on ADLs: _____

Instrumental Activities of Daily Living (IADLs)	Independent (no help)	Some Human Help Needed	Lots of Human Help Needed
Meal Preparation	☐	☐	☐
Shopping	☐	☐	☐
Medication Management	☐	☐	☐
Money Management	☐	☐	☐
Using a Telephone	☐	☐	☐
Light Housework	☐	☐	☐
Heavy Housework	☐	☐	☐
Transportation	☐	☐	☐

Comments on IADLs: _____

In Home Services Eligibility

Can the client perform chore activities without help? ☐ Yes ☐ No

Comment on the client's inability to perform chore services:

_____

Client requires Home Health Aide based on physician's orders? ☐ Yes ☐ No

Does the client have cognitive or behavioral impairment that requires supervision because they may pose a serious health or safety hazard to self or others? ☐ Yes ☐ No