

**Summit County Lead-Based Paint Hazard Control Program (SCLBPHCP)
Akron Lead Hazard Reduction Demonstration Grant Program (ALHRDGP)**

Client Documentation Check Off List

For our program to process your application, all documentation must be included with the application. These forms are needed for all household members. Please check mark the items that pertain to your household and return those items along with the completed application.

Applications can be returned during business hours Monday—Friday between the hours of 9:00 am to 3:00 pm.

Program Eligibility

- Occupied home located in the City of Akron
- Children living in the home under the age of 6 years old
- Income cannot exceed program income guidelines (see brochure)
- Property taxes must be current or on a Summit County Tax Payment Contract
- Rental properties must be registered with the City of Akron and Summit County

Application Documentation Requirement for all household members

Homeowners and household members

- Complete copy of your 2011 Federal Income Tax Return and 2011 W-2
- Copy of the children's birth certificates
- Summit County Consent to Release Confidential Information form for each child
- Copy of the social security cards for applicant and co-applicant
- Court documentation for (adoption, custody and foster child cases)
- Application must be signed by the owners & spouses, even if their name is not on the deed or mortgage
- Must have homeowner's insurance (if not, it will need to be purchased upon approval)

Landlord

- Application must be sign by the owners & spouses, even if their name is not on the deed or mortgage
- Must have homeowner's insurance (if not, applicant will be notified when it will be need to be purchased)
- Completed tenant application

Tenant

- Complete copy of your 2011 Federal Income Tax Return and 2011 W-2
- Copy of the children's birth certificates
- Summit County Consent to Release Confidential Information form for each child
- Copy of the social security cards for applicant and co-applicant
- Court documentation for (adoption, custody and foster child cases)
- Must have renter's insurance (if not, it will need to be purchased upon approval)

**All client appointments are scheduled during regular business hours Monday-Friday from 9:00 am to 3:30 pm.*



EAST AKRON NEIGHBORHOOD DEVELOPMENT CORPORATION (EANDC)
1046 S. Arlington Street, Akron, OH 44306 Office 330-773-2058 Fax 330-773-2079

- Summit County Lead-Based Paint Hazard Control Program (SCLBPHCP)
 Akron Lead Hazard Reduction Demonstration Grant Program (ALHRDGP)

APPLICANT'S INFORMATION

Please check marital status

Single Married

Applicant's name (First, Middle, Last) _____ Social Security # _____

Address no., street, apt. number _____ City, Zip _____

(Area code) Home phone no. _____ (Area code) Work phone no. _____ (Area code) Cell phone no. _____

E-Mail Address _____

Employer _____

Address (City, State, Zip Code) _____

How Long Employed _____ Title/Position _____ Annual Salary \$ _____

SPOUSE/CO-APPLICANT'S INFORMATION

Please circle marital status

Single Married

Spouse/Co-Applicant's name (First, Middle, Last) _____ Social Security # _____

(Area code) Home phone no. _____ (Area code) Work phone no. _____ (Area code) Cell phone no. _____

E-Mail Address _____

Employer _____

Address (City, State, Zip Code) _____

How Long Employed _____ Title/Position _____ Annual Salary \$ _____

HOUSEHOLD INFORMATION – TOTAL HOUSEHOLD INCLUDING APPLICANT & SPOUSE/CO-APPLICANT'S

Please list all household members currently living in your household. (i.e. relatives, friends, etc.)

Name	Date of Birth	Age	Relationship
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please indicate main contact for this application. Applicant Co-Applicant/Spouse Both

Best number to reach contact person? Home Work Cell Best time to call? Morning Afternoon Other _____

Best time to set-up an appointment for you during business hours _____ am or _____ pm.

INCOME INFORMATION

(Trust funds, social security, supplemental security income, pension, interest, dividends, annuity, worker's compensation, disability, aid to dependent children, unemployment, child support and alimony)

Source _____
Account No. _____
Monthly Amount \$ _____

Address _____
Case Worker _____

Source _____
Account No. _____
Monthly Amount \$ _____

Address _____
Case Worker _____

Source _____
Account No. _____
Monthly Amount \$ _____

Address _____
Case Worker _____

HOMEOWNER/RENTER'S INSURANCE INFORMATION

****TO BE ELIGIBLE FOR THE PROGRAM, HOMEOWNER/RENTER'S MUST HAVE INSURANCE****

Do you have insurance? Yes No

Please list your Insurance Company _____

Telephone Number _____ Fax Number _____

PROPERTY INFORMATION

If your property is under a land contact has it been recorded with the County of Summit Yes No N/A

If yes, when was it recorded? _____

OTHER WORK COMPLETED ON YOUR HOME

Have you received assistance on your home by another agency? Yes No

If yes, which agency provided assistance? City of Akron Weatherization Rebuilding Together Other _____

What improvements were addressed? Vinyl Siding Windows Doors Furnace Hot Water Tank Insulation
 Roof Repair/Replacement Electrical Plumbing Handicap Access Other _____

What year were the improvements completed? _____

What other assistance is needed for your home? Vinyl Siding Windows Doors Furnace Hot Water Tank

Plumbing Roof Repair/Replacement Electrical Insulation Handicap Access Other _____

HOW DID YOU HEAR ABOUT THE PROGRAM?

Summit County Health Department City of Akron Planning Department Neighbor went through the Program

Ace It Construction Buckeye Construction KIP Construction

JAC General Contractors Inc Stillwater Construction Your Construction

EANDC Referral Family/Friend HUD

Inspector Referral _____ Other _____

OPTIONAL INFORMATION

****THIS INFORMATION IS USED FOR FEDERAL AND STATISTICAL INFORMATION ONLY ****

- Please list your race American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White American Indian or Alaska Native and White Asian and White Black or African American and White American Indian or Alaska Native and Black or African American Other _____
- I choose not to answer the above question/section.

****LEAD BLOOD TESTING IS A PROGRAM RECOMMENDATION****

Has your child/children ever been tested for lead poisoning? Yes No

1. Date of blood test _____
2. Physicians name that conducted the test _____
3. Results (positive or negative, please list result number) _____
4. Do you live in or regularly visit a home built before 1978? Yes No

RELOCATION INFORMATION

“WE WILL RELOCATE THE NUMBER OF FAMILY MEMBERS YOU HAVE LISTED ON THE FRONT OF THIS APPLICATION”

This section of the application will be used to formulate a relocation plan for your family. Due to the lead hazards found in your home, you and your family must relocate while the contractor makes your home lead safe. **We strongly encourage all applicants applying to the program to relocate themselves with a family member or friend.** In case you are not able to do so, the program does provide housing. If a relocation house is needed the start of the lead abatement work would be scheduled once a lead safe property is available.

Please answer the following questions.

1. Are you able to relocate you and your family? Yes No
If no, please list the number of family members to be relocated. _____
2. How much notice do you require before being relocated? 1 week 2 weeks 1 month
3. Do you require a handicap accessible facility? Yes No

Applicant’s Comment Section (Please add any comments that you feel will assist us in evaluating your application)

**AUTHORIZATION FOR DISCLOSE AND CREDIT CHECK
 AUTHORIZATION TO OBTAIN VERIFICATION OF INFORMATION
 AUTHORIZATION TO RELEASE INFORMATION**

I/we authorize Summit County Lead-Based Paint Hazard Control Program or Lead Hazard Reduction Demonstration Grant Program to release copies of my/our proof of income, birth certifications, this agreement, lead and or rehabilitation cost, list of work specifications, contract agreements, credit reports, loan documents to the Summit County Health District, other City of Akron Departments, East Akron Neighborhood Development Corporation (EANDC), NeighborWorks, Summit County and other program partners. The program partners may be able to offer financial assistance for improvements to your home based on qualifications.

I/we hereby grant permission to EANDC, Summit County Health District, and the City of Akron Departments to run credit report(s), verify income, proof of insurance and proof of homeownership. I/we give permission to EANDC to obtain verification of information that is necessary to process my/our application for the Summit County Lead-Based Paint Hazard Control Program and the Lead Hazard Reduction Demonstration Grant Program. EANDC is authorized to release and verify all information on this application. The purpose or need for disclosure is for evaluation and monitoring purposes only.

I/we state that I/we have read and fully understand the above statements as they apply to me/us and do herein expressly consent to disclosure for the purpose of need and the extent or nature as stated above. A photographic or fax copy of this authorization may be deemed to be the equivalent of the original and may be used as a duplicate original. The information is for the confidential use of the above mentioned agencies/organizations in determining my/our credit worthiness for a grant, installment loan, and/or deferred loan or to confirm information that I/we have supplied. In addition, I/we also understand that the documents supplied are subject to reverification as needed even after the date of grant/loan disbursement. If I/we do not qualify, withdraw from the program or are denied assistance by the SCLBPHCP or ALHRDGP program(s) the property owners will be responsible for all code violations and lead hazards present at their property.



Initial _____

Initial _____

Date _____

Date _____



Written Acknowledgement of Receipt of Pamphlets

I have received a copy of the pamphlets **Renovate Right** and **Protect Your Family from Lead in Your Home**, informing me of the potential risk of lead hazard exposure from renovation activity to be performed in my dwelling unit. To complete the application I have initialed above that these were available to me when I/we applied to the program.

I certify under penalty of law that the information contained in this application is true, accurate and complete to the best of my knowledge. I understand that there are significant penalties for submitting false information, including the possibility of fines and imprisonment for knowing violations.

Applicant's Signature _____

Date _____

Spouse/Co-Applicant's Signature _____

Date _____

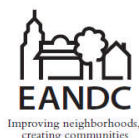
Program Use Only

Date Application was received ____/____/____

Date Application sent to **Summit County Health** ____/____/____

Date Application sent to City of Akron Planning Department ____/____/____

Date Application sent to _____ ____/____/____



**SUMMIT COUNTY COMBINED GENERAL HEALTH DISTRICT
CONSENT TO RELEASE CONFIDENTIAL INFORMATION**

Name _____ Date of Birth _____

Address _____ Phone number _____

City, State, Zip _____

Parent/Guardian _____

Summit County Combined General Health District will keep your record in their medical files and will keep your record confidential. We must have your permission to give other people or agencies information from your record. Except as otherwise required by law and subject to our professional judgement, you may choose what information the health department can share and who can get the information. **Upon written request, you have the right to withdraw your consent at any time.**

I allow Summit County Combined General Health District to exchange information from my medical records so that I (my family member) can get the care I (they) need. During the next year, I give Summit County Combined General Health District permission to exchange information with the following agencies:

BEACON JOURNAL CHARITY FUND
CHILDREN'S HOSPITAL MEDICAL CENTER
BCMh
BLICK CLINIC
CHILD GUIDANCE CENTERS
COUNTY BOARD OF MRDD
HELP ME GROW
OHIO DEPARTMENT OF HEALTH

OHIO REHABILITATION SERVICES COMMISSION
OHIO DEPT. OF JOB AND FAMILY SERVICES
PUBLIC HEALTH DEPARTMENTS
PREGNANCY CARE SERVICES
SOCIAL SECURITY ADMINISTRATION
UNITED DISABILTY SERVICE
WIC
HEALTHY HOMES & LEAD POISON PREVENTION PROGRAM

OTHER _____

Managing Physician _____ Address _____

Primary Care Physician _____ Address _____

Hospital _____ Address _____

School _____

Insurance Provider _____

I understand that by signing this consent, I give Summit County Combined General Health District permission to release or obtain any medical information needed for treatment, diagnosis or payment purposes to the above listed agencies. I agree that a copy of this form may be used instead of the original.

This form has been fully explained to me, and I understand its contents.

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____