



HEALTHY HOMES UNIVERSITY PROGRAM APPLICATION

Part I. Please fill out the information below:

Renter	Homeowner (If Different)
Name: _____	Name: _____
Address: _____ Apt. _____	Address: _____ Apt. _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
County: _____	County: _____
Home Phone: _____ Cell Phone: _____	Home Phone: _____ Cell Phone: _____
Email: _____	Email: _____

Part II. Please complete for EVERY child under the age of 18 years who lives in the house:

Child 1: Most Severe Asthma (i.e. symptoms, emergency department visits, missed school days, etc.)

Name of child: _____	Your relationship to child: _____
Date of birth: _____ Sex (M/F): _____ Race (Optional): _____	
What kind of health care coverage does this child have? Check all that apply: <input type="checkbox"/> PHP Medicaid <input type="checkbox"/> McLaren Medicaid <input type="checkbox"/> MI Child <input type="checkbox"/> Health Plan of MI <input type="checkbox"/> Ingham Health Plan <input type="checkbox"/> Parents Employer Other: _____	
Name and phone number of the legal guardian/parent of this child: _____	
Name and phone number of another contact person (i.e. grandparent, aunt/uncle, friend, etc) of this child: _____	
Name and phone number of this child's doctor(s) for his/her asthma: _____	
Have you ever been told by a doctor or nurse that this child has asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
During the past month, how often has this child used their rescue inhaler or nebulizer medication (such as albuterol)?	<input type="checkbox"/> 3 or more times/day <input type="checkbox"/> 1 or 2 times/day <input type="checkbox"/> 2 or 3 times/week <input type="checkbox"/> Once/week <input type="checkbox"/> Not at all
During the past month, how many days did this child have any symptoms of asthma (like cough, wheeze and/or shortness of breath)?	_____ Number of Days <input type="checkbox"/> Don't Know
During the past month, on how many days did symptoms of asthma make it hard for this child to stay asleep?	_____ Number of Days <input type="checkbox"/> Don't Know
During the past month, how many days did this child miss daycare, preschool or school because of asthma?	_____ Number of Days <input type="checkbox"/> Don't Know
In the past 12 months, how many times did this child visit an emergency room or urgent care center because of asthma?	_____ Number of Times <input type="checkbox"/> Don't Know
In the past 12 months, how many times did this child see a doctor or other health professional for urgent treatment of worsening asthma symptoms?	_____ Number of Times <input type="checkbox"/> Don't Know
In the past 12 months, how many different times did this child stay in a hospital overnight or longer because of asthma?	_____ Number of Times <input type="checkbox"/> Don't Know

For additional children, please complete reverse side of this sheet.

Staff Use Only:
Subtotal: _____
Total: _____

Child 2

Name of child: _____	Your relationship to child: _____	
Date of birth: _____	Sex (M/F): _____	Race (Optional): _____
Have you ever been told by a doctor or nurse that this child has asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know

Child 3

Name of child: _____	Your relationship to child: _____	
Date of birth: _____	Sex (M/F): _____	Race (Optional): _____
Have you ever been told by a doctor or nurse that this child has asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know

Child 4

Name of child: _____	Your relationship to child: _____	
Date of birth: _____	Sex (M/F): _____	Race (Optional): _____
Have you ever been told by a doctor or nurse that this child has asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know

Child 5

Name of child: _____	Your relationship to child: _____	
Date of birth: _____	Sex (M/F): _____	Race (Optional): _____
Have you ever been told by a doctor or nurse that this child has asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know

Child 6

Name of child: _____	Your relationship to child: _____	
Date of birth: _____	Sex (M/F): _____	Race (Optional): _____
Have you ever been told by a doctor or nurse that this child has asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't Know

Part III. Please answer the following questions by checking **Yes**, **No**, or **Don't Know**

	Yes	No	Don't Know	Staff Use Only
1. Does any occupant in the home have a disability? Explain: _____				
2. Is this a single head of household?				
3. Do you plan to move within the next 12 months?				
4. What is the ZIP Code of this home?	ZIP: _____			
5. What year was this home constructed?	Year: _____			
6. Does anyone smoke in the home?				
7. Are there any other sources of smoke in the home? If yes, please check: <input type="checkbox"/> Gas Stove <input type="checkbox"/> Wood Stove <input type="checkbox"/> Kerosene Heaters <input type="checkbox"/> Fireplace Other _____				
8. Does the home have any pets such as dogs, cats, hamsters, birds, or other feathered or furry pets that spend time indoors?				
9. In the past 30 days, has anyone seen cockroaches, mice, rats or other rodents in the home?				
10. In the past 30 days, has anyone seen or smelled mold or a musty odor inside the home? (Do not include mold on food.)				
11. In the past 12 months, has a child in this home been taken to the doctor, urgent care or emergency room for an injury? If yes, check type: <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Burn <input type="checkbox"/> Electric Shock <input type="checkbox"/> Poisoning <input type="checkbox"/> Cut Other _____				
12. How did you hear about this program? <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor/Nurse <input type="checkbox"/> Community Activity <input type="checkbox"/> Government Agency Other _____				
13. What is the language(s) spoken in the home?				

Part IV. Please complete and attach copies. **WE CANNOT PROCESS WITHOUT INCOME DOCUMENTATION**

1. What is the total annual income of the household (include everyone >18 years of age)? Attach copies of last year's W2s or 2 current pay stubs and proof of other income (i.e., disability, alimony, child support, social security, and any federal assistance, etc.)	\$ _____	
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I verify that the answers provided above are true.

Name (Please print)

Signature

Date

Mail completed application to:

**Healthy Homes Section
P.O. Box 30195, Lansing, MI 48909**

FOR STAFF USE ONLY

DATE APPLICATION RECEIVED: _____	INITIALS: _____
DATE INCOME DOCS RECEIVED (if different) : _____	INITIALS: _____
DATE APPLICATION APPROVED/DENIED: _____	INITIALS: _____
DATE APPLICATION ENTERED INTO DATABASE: _____	INITIALS: _____

Staff Use Only:
Staff Factor: _____
Subtotal: _____