



ALE

MDHHS-Lead Services Section
PO Box 30037, Suite 410
Lansing, MI 48909
Michigan.gov/MiLeadSafe
MDHHS-LeadApps@michigan.gov
Ph: 517-335-9390
Fx: 517-284-9956

APPLICATION

Lead Safe Home Program

If you currently live in a lead action level exceedance community, please complete and submit this application.

PART I: PROPERTY INFORMATION

This property is:

- Owner Occupied
- Rental Property
- Land Contract
- Vacant

This property currently has:

- Water
- Electricity
- Heat
- Roof Leaks
- Previous Roof Leaks

The water service line has:

- Been replaced – Date: _____
- Is scheduled to be replaced
- Unsure

Property address: _____

Apt #: _____

City: _____

State: _____

Zip: _____

County: _____

Number of units in building: _____

All units must submit application

PART 2: APPLICANT INFORMATION

Name: _____

Total number living in household: _____

Telephone number: _____

Alternate telephone number: _____

Email address: _____

How did you hear about this program? _____

PART 3: OWNER INFORMATION (COMPLETE ONLY IF DIFFERENT FROM APPLICANT)

Type of ownership:

- Individual
- LLC
- Partnership
- Corporation

Name: _____

Email address: _____

Address: _____

City: _____

State: _____

Zip: _____

Telephone number: _____

Alternate telephone number: _____

For Office Use Only

Application Logged In: _____ App No: _____ Denial: _____ Reason: _____

BLL: _____ Partnership: _____ Fund Source: _____

Income: _____ Target Area: _____ Funding Maximum: _____

Part V: _____ Total Application: _____ APPROVED FOR LSHP ENROLLMENT: _____

PART 4: OCCUPANTS

Please complete the table below for all occupants (adults and children). Attach an extra sheet of paper, if necessary.

All Occupant's (living in the home) First & Last Name	Date of Birth	Medicaid Beneficiary Number	Is this person pregnant?	Optional			Has this person been told by a doctor / nurse that s/he has asthma? If yes, in the last year, what is the number of times they: 1) Visited the ER? 2) Were hospitalized?		Program Use	
				Identified Gender	Ethnicity: Hispanic / Latino?	Race: A-Asian B-Black H-Hawaiian / Pacific Islander I-American Indian / Alaskan Native O-Other W-White	Venous BLL	Date of most recent test		
	/ /						1)	2)		
	/ /						1)	2)		
	/ /						1)	2)		
	/ /						1)	2)		
	/ /						1)	2)		
	/ /						1)	2)		
	/ /						1)	2)		
Visiting Children First & Last Name							How long does the child visit?			
	/ /						Hours/day?	Days/week?	Weeks/year?	
	/ /									
	/ /									

PART 5: SIGNATURE

By signing I (occupant and property owner) permit MDHHS to perform a lead investigation on this property. I agree to fully cooperate in potential lead hazard control work. I understand I must disclose results of lead-activities to potential lessees or buyers of this property. I understand MDHHS is not responsible for uninsured properties or for any damages to real or personal property. I authorize MDHHS to obtain blood lead laboratory results through the Michigan Care Improvement Registry. I agree to let MDHHS share these results privately with authorized program representatives. I authorize the use of information from this application and lead investigation for a research study. I understand the study will not use my personal health information. I answered all questions truthfully and to the best of my knowledge. I understand there is a penalty for false or fake statements. This penalty is from U.S.C. Title 18, sec 1001. It states: "Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly falsifies, or makes, or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than five years, or both." **I understand signature(s) are required for processing.**

_____	_____
Print Property Owner Name	Print Tenant Name (if applicable)
_____	_____
Property Owner Signature	Tenant Signature (if applicable)
_____	_____
Date	Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need the above services, contact the MDHHS Section 1557 Coordinator.

If you believe that MDHHS has failed to provide the above services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: MDHHS Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the MDHHS Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, 4th Floor
P.O. Box 30195
Lansing, MI 48909

517-284-1018 (Main), TTY users call 711, 517-335-6146 (Fax),
MDHHS-ComplianceOffice@michigan.gov

You can also file a civil rights complaint with the responsible federal agency.

<p>If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at:</p> <p>U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD)</p> <p>Complaint forms are available at https://bit.ly/2IKsHMS.</p>	<p>If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by:</p> <p>Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all information requested in the form.</p> <p>To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410</p> <p>Fax: 202-690-7442; or Email: program.intake@usda.gov</p>
---	---

MDHHS is an equal opportunity provider.