



**SUMMIT COUNTY PUBLIC HEALTH (SCPH)  
HUD LEAD-BASED PAINT HAZARD REDUCTION GRANT PROGRAM  
OCCUPIED RENTAL APPLICATION**

**Review of Grant Eligibility & How the Program Works**



Rental owners and their tenants may apply if all the following criteria are met:

- The home is built before 1978.
- A child under the age of 6 lives in the rental or visits on a regular basis.
- The home meets local ordinances and housing codes.
- The home is free of clutter, insects, rodents, and unsanitary conditions.
- Tenant income is within 2020 HUD Income Guidelines (subject to change).

1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 Persons
\$ 42,750	\$ 48,850	\$ 54,950	\$ 61,050	\$ 65,950	\$ 70,850	\$ 75,750	\$ 80,600

Note: Rental units are income qualified based on the tenant(s) income.

How the Program Works After the Application is Approved

- A SCPH Lead Risk Assessor will contact you to schedule a time to do a lead risk assessment. A report will be mailed with a list of the lead hazards to you the tenant and the owner(s).
- A pre-bid meeting is scheduled at the house to allow contractors to see the work that needs to be done.
- The Contractor with the lowest most responsive bid is awarded the job and the County of Summit will hold the contract with the winning contractor.
- Relocation is required while the lead work is being completed at the home, and it is encouraged that the tenant(s) stay with friends and/or family. If this is not an option, SCPH will select and pay for a hotel for relocation. The tenant MUST provide a debit/credit card at check in for any incidentals. Only the individuals listed on the application as living in the home are eligible for relocation. Failure to follow hotel policies may result in a loss of your reservation. SCPH will not make additional arrangements and the owner and/or tenant are not permitted to return to the home until the lead work is completed and a clearance inspection has been conducted. SCPH must be made aware of any animals that will be going to the hotel prior to reservations being made. Boarding of animals is not covered by the program. Animals may NOT be left either inside or outside at the home. If any animals are left, Animal Control will be contacted to remove the animals and the owner will be responsible for any fees to get the animal(s) back.
- SCPH staff will call the owner and tenant to give the date that the contractor will begin lead work. A time will be scheduled to plan for relocation to a friend or family home or to a hotel with a kitchenette, of SCPH choosing, paid by the Program. No food will be purchased using the program. Only individuals listed on the application as living in the home will be permitted to use the hotel pool, additional guests are not permitted to use hotel amenities.
- The tenant(s) and/or owners will clear areas where work is being done and take down window covers.
- Once lead work begins, no one can enter the residence until it is tested and found lead safe. SCPH staff will call the tenants and advise when they are able to return.

All occupants of the home must follow these guidelines. Failure to comply may result in termination of participation in the Lead Paint Hazard Reduction Grant Program. Please call 330-926-5600 or 330-643-8013 if you have questions or concerns.

If you understand and agree to these guidelines, please sign and date below and return with your application.

\_\_\_\_\_  
Signature of Tenant Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Tenant Co-Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Rental Owner or Authorized Representative

\_\_\_\_\_  
Date



## SUMMIT COUNTY PUBLIC HEALTH

### HUD LEAD-BASED PAINT HAZARD REDUCTION PROGRAM

**PLEASE MAIL, EMAIL, OR BRING THE APPLICATION AND COPIES OF THE REQUIRED DOCUMENTS TO ONE OF THE FOLLOWING ADDRESSES:**

Summit County Public Health  
1867 W Market Street  
Akron, Ohio 44313  
ATTN: Lead Program  
PH (330) 926-5600 FAX (330) 923-6436  
Website: <https://www.schd.org>  
Email: [lead@schd.org](mailto:lead@schd.org)

County of Summit  
Department of Community and Economic Development  
175 S. Main St., Suite 207  
Akron, OH 44308  
PH (330) 643-8013  
Website: <https://co.summitoh.net>  
Email: [hmiller@summitoh.net](mailto:hmiller@summitoh.net)

### TENANT REQUIRED DOCUMENTS:

- ☐ **Federal Tax Return** – a copy of the 2019 tax return with all Schedules which must be signed and dated for all adults 18 years and older.
- ☐ **W-2** Statement of Earnings for 2019 for all adults 18 years and older
- ☐ **Social Security Benefits Statement** (Form SSA-1099) for 2019
- ☐ Notarized letter for every adult, 18 years or older, in the home, who does not file a Federal Tax return with the reason – unemployed, senior citizen, full-time student, or other
- ☐ **Last 6 pay stubs** for all adults 18 years and older who are employed
- ☐ **Social Security Award Letter** for 2019
- ☐ **Determination of Unemployment Compensation Benefits** document with date first paid out
- ☐ Notarized letter signed and dated for every person living in the home over age 18 years with no income
- ☐ **Birth certificates** for all children under 6 living in the home or visiting the home
- ☐ Notarized letter signed and dated by the parent or guardian of the visiting child under the age of 6. Write the child's name, birthdate, and the **number of days a week** and **hours a day** that the child stays in the home
- ☐ Court documents for adoption/legal custody/foster care
- ☐ **Pension document** with the 2019 yearly amount
- ☐ Divorce documents/decreed/separation agreement
- ☐ **Power of Attorney, LLC, or Corporation document** which names the Rental Owner alternate who can sign HUD Lead Based Paint Hazard Reduction Program documents, if needed
- ☐ **Last 3 bank account statements** for all adult occupants - checking, savings, credit union  
**Please write source of income for all unidentified bank deposits.**

## RENTAL OWNER with TENANT REQUIRED DOCUMENTS:

- ☐ **Homeowner Insurance policy** with the current effective dates and annual premium amount

The above information will be required for all adults living in the home. Please provide only the documents that are applicable to you. Additional documents may be requested as your application is reviewed. If you cannot make copies of documents, we can make copies for you.



SUMMIT COUNTY PUBLIC HEALTH  
HUD LEAD-BASED PAINT HAZARD REDUCTION PROGRAM

TENANT APPLICATION

Owner Name/s Listed on the Property Deed: \_\_\_\_\_

Owner Representative (POA) Name: \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address for Owner: \_\_\_\_\_

**PART 1: TENANT APPLICANT INFORMATION**

NAME (First) Middle (Last)

RENTAL ADDRESS (City) (Zip Code)

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Is English your first language? ☐ Yes ☐ No My first language is: \_\_\_\_\_

☐ Female ☐ Male Are you a Veteran? ☐ Yes ☐ No Are you Hispanic/Latino? ☐ Yes ☐ No

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Please check one of the following: (Required for Federal Funding Purposes)

☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Other Multi Racial

☐ Native Hawaiian/Other Pacific Islander ☐ Asian/White ☐ American/Indian/Alaskan Native/White

☐ American Indian/Alaskan Native/Black/African American ☐ Black/African American/White

**List your employer/s and income:**

☐ Check here if you are unemployed.

Employer/Employers		Amount of Pay Check (Monthly Gross, Before Taxes)
Current		
2019		

**List OTHER sources of income:**

	Yes	No	Total Amount Per Month	
			Current	2019
Child Support	<input type="checkbox"/>	<input type="checkbox"/>		
Alimony	<input type="checkbox"/>	<input type="checkbox"/>		
Pension	<input type="checkbox"/>	<input type="checkbox"/>		
Social Security or SSI	<input type="checkbox"/>	<input type="checkbox"/>		
Disability Benefits	<input type="checkbox"/>	<input type="checkbox"/>		
Unemployment Benefits	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have other income?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please write and attach page listing the income.	

**PART 2: CO-APPLICANT INFORMATION**

☐ Check here if there is **no** co-applicant and go to Part 3 of the application.

TENANT CO-APPLICANT NAME (First) Middle (Last)

RENTAL ADDRESS (City) (Zip Code)

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Is English your first language? ☐ Yes ☐ No My first language is: \_\_\_\_\_

☐ Female ☐ Male Are you a Veteran? ☐ Yes ☐ No Are you Hispanic/Latino? ☐ Yes ☐ No

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Please check one of the following: (Required for Federal Funding Purposes)

☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Other Multi Racial

☐ Native Hawaiian/Other Pacific Islander ☐ Asian/White ☐ American/Indian/Alaskan Native/White

☐ American Indian/Alaskan Native/Black/African American ☐ Black/African American/White

**List your employer/s and income:**

☐ Check here if you are unemployed.

	Employer/Employers	Amount of Pay Check (Monthly Gross, Before Taxes)
Current		
2019		

**List OTHER sources of income:**

	Yes	No	Total Amount Per Month	
			Current	2019
Child Support	<input type="checkbox"/>	<input type="checkbox"/>		
Alimony	<input type="checkbox"/>	<input type="checkbox"/>		
Pension	<input type="checkbox"/>	<input type="checkbox"/>		
Social Security or SSI	<input type="checkbox"/>	<input type="checkbox"/>		
Disability Benefits	<input type="checkbox"/>	<input type="checkbox"/>		
Unemployment Benefits	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have other income?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please write a page listing the income and return with the Application.	

**PART 3: OTHER TENANTS**

Write in the names of OTHER people currently living in the home.

Do not write the Applicant or Co-Applicant names here.

Name	Relationship to Applicant	Date of Birth	Social Security Number (last 4 numbers)

**Do you care for children younger than 6 years of age in your home?**

☐ Yes ☐ No

**If yes, fill in the next section.**

Name of Child	Birthdate	Days per Week	Hours Per Day

## PART 4: ASSETS

List all current bank accounts and the type of account, except IRA Accounts.

☐ Check here if no bank accounts.

Name of Bank or Credit Union	Checking or Savings Account	Balance

List all Stocks, Bonds, Certificate of Deposits, Securities, IRA's, or Other.  
(Withdrawals from accounts are counted as household income.)

☐ Check here if no stocks, bonds, CDs, etc.

Name of Stock, Money Market Account, Government Bond, Or Other	Approximate Value

## PART 5: PERMISSION TO RELEASE OR VERIFY APPLICANT INFORMATION

Inquiries may be made about items listed below for the applicant, co-applicant, and other occupants of the household age 18 and over. Failure to verify information may result in a delay or may result in your application not being approved.

### APPLICANT INFORMATION COVERED

I/we authorize and release the County of Summit and/or HUD to obtain information that is pertinent to my/our eligibility for the Summit County Public Health Lead-Based Paint Hazard Control Grant Program and to verify the information that I/we have provided.

Alimony or Separation Payments	Full-Time Student Status	Social Security Benefits
Assets (all sources)	Handicap Assistance Expense	Tax Returns
Assets on Deposit	Income (all sources)	Unemployment Benefits
Bank Accounts	Income from Business	VA Benefits
Child Care Expenses	Liens	Other:
Child Support Payments	Medical Expenses	
Employment	Pension and Annuities	

I/we acknowledge and understand:

The Summit County Public Health representative has my/our permission to complete or fill in missing information on my/our application.

\_\_\_\_\_  
Signature of Tenant Applicant                      Date

\_\_\_\_\_  
Signature of Tenant Co-Applicant                      Date

\_\_\_\_\_  
Signature of Other Adult Tenant                      Date

\_\_\_\_\_  
Signature of Other Adult Tenant                      Date



## PART 6: TENANT Agreement

The Tenant(s) understands that it is a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction (Section 1001 of Title 18 of US Code).

The Tenant(s) understands that approval of the application is not guaranteed. The application may not be approved due to income eligibility, the condition of the house, or the cost of the amount of work needed.

The Tenant(s) understand(s) that a lead risk assessment must be completed on the home by Summit County Public Health, if the application is approved. Access to each room, from attic to basement, and a clear path to each window are needed to test the paint. Animals must be kept outside during the lead risk assessment. If the Lead Risk Assessor does not have access to each room and window, or pets are not contained, the lead risk assessment will be canceled and rescheduled. A lead risk assessment report will be mailed. It will list lead hazards and what lead work may be provided.

The Tenant(s) understand(s) that all occupants and pets must move out while lead work is being done; and, will make plans to move in with a friend or family member. A hotel suite with a furnished kitchen will be reserved and paid for by the Grant. The Tenant(s) will need to provide a credit card to pay for miscellaneous charges, when checking in.

The Tenant(s) understand(s) that, before moving out, furniture needs to be moved in work areas; window treatments need to be removed where windows are being replaced; access to windows must be clear; porches must be clear; and, valuables must be secured. The property must be pest and rodent free. The Applicant(s) understand(s) that LBPHCP is not responsible for anything broken or stolen before, during, or after the work is done.

The Tenant(s) understands that any verbal or physical abuse or threats to Summit County staff, contractors, or their employees may result in the immediate termination of LBPHCP assistance and that any work performed will be at the expense of the Applicant(s).

The Tenant(s) understands that the Rental Owner cannot evict, except for serious or repeated violation of the terms of the Lease, for violation of applicable Federal, State, or Local law, or for other good cause.

The Tenant(s) understands that the Rental Owner cannot raise the rent as a result of the work done by the HUD Grant.

The Tenant(s) understands that a photocopy of this application is valid as the original.

The Tenant(s) confirm(s) that a copy of the Notice of Privacy Practices has been received.

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Signature of Tenant Applicant  
Date

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Date                      Signature of Tenant Co-Applicant

## PART 7: WALK AWAY POLICY

Regardless of eligibility, under certain circumstances, an applicant may not receive assistance through the Lead Based Paint Hazard Reduction Program. Such circumstances include, but are not limited to:

- The tenant and/or applicant becomes verbally or physically abusive and/or threatens staff members
- During the course of the lead abatement work the owner and/or tenant continually fails to cooperate with staff or contractors
- Applicant knowingly misrepresents information relevant to their eligibility for assistance
- Following the initial inspection of the home, a determination is subsequently made that the home is not structurally sound
- Failure on the part of the applicant/owner to demonstrate pride of ownership. Conditions included under pride of ownership include, but not limited to:
  - Abuse of animals: evidence of unsanitary conditions
  - Illegal or improper use of the property
  - Housekeeping and maintenance: extreme conditions of clutter or filth in or around the house

Under any of the circumstances assistance may be withheld and/or terminated at the discretion of the program administrator.

I/we acknowledge that we have read and do thoroughly understand and by my/our signatures below do affirm the above.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Rental Owner or Authorized Representative

\_\_\_\_\_  
Date



## Summit County Public Health

1867 W. Market St. • Akron, OH 44313 • 330-923-4891

# NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how your medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

<b>Get an electronic or paper copy of your medical record</b>	<ul style="list-style-type: none"> <li>You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.</li> <li>We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.</li> </ul>
<b>Ask us to correct your medical record</b>	<ul style="list-style-type: none"> <li>You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.</li> <li>We may say “no” to your request, but we’ll tell you why in writing within 60 days.</li> </ul>
<b>Request confidential communications</b>	<ul style="list-style-type: none"> <li>You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.</li> <li>We will say “yes” to all reasonable requests.</li> </ul>
<b>Ask us to limit what we use or share</b>	<ul style="list-style-type: none"> <li>You can ask us <b>not</b> to use or share certain health information for treatment, payment, or our operations.                             <ul style="list-style-type: none"> <li>We are not required to agree to your request, and we may say “no” if it would affect your care.</li> </ul> </li> <li>If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.                             <ul style="list-style-type: none"> <li>We will say “yes” unless a law requires us to share that information.</li> </ul> </li> </ul>
<b>Get a list of those with whom we’ve shared information</b>	<ul style="list-style-type: none"> <li>You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.</li> <li>We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.</li> </ul>

<b>Choose someone to act for you</b>	<ul style="list-style-type: none"> <li>• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.</li> <li>• We will make sure the person has this authority and can act for you before we take any action.</li> </ul>
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<b>File a complaint if you feel your rights are violated</b>	<ul style="list-style-type: none"> <li>• You can complain if you feel we have violated your rights by contacting us using the information on page 1.</li> <li>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <a href="http://www.hhs.gov/ocr/privacy/hipaa/complaints/">www.hhs.gov/ocr/privacy/hipaa/complaints/</a>.</li> <li>• We will not retaliate against you for filing a complaint.</li> </ul>
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## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

<b>In these cases, you have both the right and choice to tell us to:</b>	<ul style="list-style-type: none"> <li>• Share information with your family, close friends, or others involved in your care</li> <li>• Share information in a disaster relief situation</li> <li>• Include your information in a hospital directory</li> <li>• Contact you for fundraising efforts</li> </ul> <p><i>If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.</i></p>
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<b>In these cases we <i>never</i> share your information unless you give us written permission:</b>	<ul style="list-style-type: none"> <li>• Marketing purposes</li> <li>• Sale of your information</li> <li>• Most sharing of psychotherapy notes</li> </ul>
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<b>In the case of fundraising:</b>	<ul style="list-style-type: none"> <li>• We may contact you for fundraising efforts, but you can tell us not to contact you again.</li> </ul>
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## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

<b>Treat you</b>	<ul style="list-style-type: none"> <li>• We can use your health information and share it with other professionals who are treating you.</li> </ul>	<i><b>Example:</b> A doctor treating you for an injury asks another doctor about your overall health condition.</i>
<b>Run our organization</b>	<ul style="list-style-type: none"> <li>• We can use and share your health information to run our practice, improve your care, and contact you when necessary.</li> </ul>	<i><b>Example:</b> We use health information about you to manage your treatment and services.</i>

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**Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

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**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

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**Help with public health and safety issues**

- We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- 

**Do research**

- We can use or share your information for health research.
- 

**Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- 

**Respond to organ and tissue donation requests**

- We can share health information about you with organ procurement organizations.
- 

**Work with a medical examiner or funeral director**

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- 

**Address workers' compensation, law enforcement, and other government requests**

- We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
- 

**Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- 

## Compliance With Other Laws

**Other provisions of law may apply to your information.** If any state or federal privacy laws require us to provide you with more privacy protections than those explained here, then we must also follow that law. For example, drug and alcohol treatment records are subject to the following restrictions:

- Information regarding participation in a treatment program or identifying a patient as a substance abuser will not be disclosed except as permitted by applicable law.
- Disclosures, other than those explicitly required by 42 CFR Part 2, require consent in writing from the patient unless the patient is incompetent, the patient condition prevents knowing or effective action, or the patient is deceased. We may not release the records of minors without the consent of the minor, except as required by law.
- Disclosures by court order require both a court order and a subpoena.
- Disclosures may be made for scientific research, program evaluations or audits, and emergencies.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

*Effective Date: 5/15/2017*

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*For questions, please contact the Summit County Public Health Privacy Official by calling 330-923-4891.*

## PART 9: MULTI-PARTY AUTHORIZATION FOR RELEASE OF INFORMATION

### SUMMIT COUNTY COMBINED GENERAL HEALTH DISTRICT

#### MULTI-PARTY AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

I hereby authorize the Summit County Combined General Health District ("Health District") to  
☐ Release ☐ Obtain (check one or both) the records as described below.  
Obtain Information From:

Agency: \_\_\_\_\_ Agency: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
☐ All Records ☐ All Records ☐ Other: \_\_\_\_\_

Agency: \_\_\_\_\_ Agency: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
☐ All Records ☐ All Records ☐ Other: \_\_\_\_\_

#### Release Information To:

##### County Agencies:

Agency: Summit County Department of Community and Economic Development  
Purpose: Determine program eligibility  
Agency: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Agency: \_\_\_\_\_  
Purpose: \_\_\_\_\_

##### Other Agency/Person

Agency/Person Name: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Agency/Person Name: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Agency/Person Name: \_\_\_\_\_  
Purpose: \_\_\_\_\_

#### Type of Information to be Shared:

You may share all or any part of my record with the agencies or persons listed above, as provided by law.

I have been offered the District's Notice of Privacy Practices and understand that these explain how the medical information of the patient may be used and disclosed. Except for research-related treatment and treatment solely for the purpose of disclosure to a third party, treatment or payment, enrollment or eligibility for benefits may not be conditioned on execution of this authorization. I understand that I may receive an accounting of disclosures upon request. I acknowledge that this authorization is voluntary and I may revoke the authorization orally, in the box below, in writing to the Health District Privacy Officer at 1867 W. Market St Akron, OH 44311, or by emailing [hipaa@schd.org](mailto:hipaa@schd.org). I understand that I cannot revoke consent for releases where SCPH has already reasonably relied upon my consent. I understand and acknowledge that this Authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), and/or Human Immunodeficiency Virus (HIV/Acquired Immune Deficiency Syndrome AIDS) test results or diagnoses (ORC3701 24.3). This form has been fully explained to me and I certify that I understand its contents.

Signature of Patient or Patient's Representative: \_\_\_\_\_  
Patient's Representative (print): \_\_\_\_\_  
Authority of Representative: \_\_\_\_\_  
Date: \_\_\_\_\_  
Expiration date or event: \_\_\_\_\_  
(if blank, your consent will automatically expire when your client relationship terminates)

**If choosing to REVOKE, complete the following section:**

**Written Revocation: I wish to cancel this Release effective:**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian or Person Authorized to revoke consent**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**



## PART 10: RENTAL OWNER(S) AGREEMENT

The Owner(s) confirms that he/she/they is/are the legal owner of the property described in this application.

The Owner(s) understands that it is a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction (Section 1001 of Title 18 of US Code).

The Owner(s) understands that the home's property tax must be paid in full. If a payment plan is set up with the County Tax Department, a copy of the plan should accompany the Application. The application will be approved after 6 payments are made.

The Owner(s) understands that the property must be registered as a rental with Summit County and with the City where the house is located.

The Owner(s) understands the property must meet local ordinances/codes - occupancy, zoning, and property maintenance.

The Owner(s) understand(s) that the property must be insect and rodent free. Proof of the job being done by a licensed Exterminator will be required.

The Owner(s) understand(s) that a lead risk assessment must be completed on the home. The lead risk assessment is completed by Summit County Public Health. Results from the lead risk assessment will be shared with the rental owner(s) and will determine what, if any lead assistance may be provided.

The Owner(s) understand that the Summit County Public Health Lead Risk Assessor will need access to each room of the home (including attic and basement) and must have a clear path to each window. Any animals must be kept outside or off the premises during the lead risk assessment. If the Lead Risk Assessor does not have access to each room and window, or pets are not contained, the lead risk assessment will be canceled until such time that the lead risk assessor feels that they have appropriate access and that the animals have been contained.

The Owner(s) understand(s) that window treatments need to be removed where windows are being replaced; access to windows must be clear; and, porches must be clear. The Owner(s) understand(s) that Grant Program is not responsible for anything broken or stolen before, during, or after the work is done.

The Owner(s) understand(s) that a 5-year *deferred forgivable* mortgage loan and a lien will be placed on the property, and understand(s) that home insurance is required for the 5-year loan period, with the County of Summit listed as an "Additional Insured". The Rental Owner(s) understand(s) that the payment of property taxes and additional assessments must be kept up-to-date.

The Owner(s) understand(s) that he/she will pay 25% of the cost of the work. The payment by check or money order is due when the mortgage loan documents are signed at the County of Summit Department of Community and Economic Development office located at 175 S. Main St., Room 207, Akron, Ohio 44308.

The Owner(s) understands that rent cannot be raised for 5 years after the HUD Lead-Based Paint Hazard Control Grant process has been completed and accepted.

The Owner(s) understands that priority for rental should be given to low income families with children under age 6 years for 5 years after the Grant Program work has been completed and accepted. A copy of every lease is required with a list of occupants and their ages.

The Owner(s) understands that the current tenant cannot be evicted, except for serious or repeated violation of the terms of the Lease, for violation of applicable Federal, State, or Local law, or for other good cause.

The Owner(s) understands that any verbal or physical abuse or threats to Summit County staff, contractors, or their employees may result in immediate termination of assistance and that any work performed will be at the expense of the Rental Owner(s).

\_\_\_\_\_  
Signature of Rental Owner  
or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Rental Owner Co-Applicant

\_\_\_\_\_  
Date

## PART 11: RENT & ADVERTISING AGREEMENT

I/we agree to advertise the rental property at

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to low to moderate income families with children less than 6 years of age for a period of 5 years from the date the lead hazard control process has been completed and accepted.

I/we understand that if a tenant vacates the rental, I/we must try to rent the property to another low to moderate income family with children less than 6 years of age, following all Fair Housing Laws.

I/we agree not to raise the rent on the above-listed property for a period of 5 years from the date the work has been completed and accepted, and agree not to raise the rent as a result of the improvements made through the Summit County Public Health HUD Lead-Based Paint Hazard Reduction Program.

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Signature of Rental Owner or Authorized Representative

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Date

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Signature of Rental Owner

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Date