



MDHHS-Lead Services Section  
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 Michigan.gov/MiLeadSafe  
 MDHHS-LeadApps@michigan.gov  
 Ph: 517-335-9390  
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## APPLICATION FOR Lead Services

### PART I: PROPERTY INFORMATION

<b>This property is:</b>	<b>This property currently has:</b>	<b>The water service line has:</b>
Owner Occupied	Water	Been replaced – Date:
Rental Property	Electricity	Is scheduled to be replaced
Land Contract	Heat	Unsure
Vacant	Roof Leaks	
	Previous Roof Leaks	

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)

<b>Type of ownership:</b>	Name: _____	Email address: _____
Individual	Address: _____	
LLC		
Partnership	City: _____	State: _____
Corporation		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: _____	<b>Total Application:</b> _____	<b>APPROVED FOR LSHP ENROLLMENT:</b> _____	

**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 (DOB)	Medicaid Beneficiary Number	Does this person have a blood lead level (*BLL) of 3.5 or higher? (children under 6 years of age only)	Is this person pregnant?	Optional		
					Identified Gender	Ethnicity: Hispanic / Latino?	Race: A-Asian B-Black H-Hawaiian / Pacific Islander I-American Indian / Alaskan Native O-Other W-White
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<b>Visiting Children First &amp; Last Name (only list children under 6 years of age)</b>	<b>DOB</b>		<b>*BLL?</b>	<b>How long does the child visit? Hours/day? Days/week? Weeks/year?</b>		<b>Ethnicity</b>	<b>Race</b>
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## PART 5: HOUSING

Please answer **all** the following questions by selecting: Yes, No, Unsure, or N/A if not applicable. Failure to provide information will be reason for denial.

### For the home/property listed in this application:

	Yes	No	Unsure	N/A
1. What is the approximate year the home was built?				
2. How long have you lived at this address?				
3. Does it have at least one bedroom?				
4. Are the property taxes paid up through the last billing cycle?				
5. Is this property owned by a federal, state, or local government agency?				
6. Is this property or tenant currently participating in a HUD program? a. If yes, which one?				
7. Is this home being used as a day care? a. If so, how many children attend?	a.)			

### For the applicant:

	Yes	No	Unsure	N/A
8. Do you agree to have your children under 6 years old tested for lead poisoning 6 months following lead work?				
9. If you are the owner, would you be willing to contribute cash or labor towards this project?				
10. Is there a woman living at this address between the ages of 16 and 45?				
11. Are there any animals living in the home? (e.g., dogs or cats)				
12. Do you understand that your household (and animals) may be asked to relocate while some or all work occurs?				

### For Landlords:

	Yes	No	Unsure	N/A
13. Have you been cited by the local prosecutor's office for a child's lead poisoning?				
14. Have you been cited by any party for non-compliance of the lead disclosure law?				

**PART 6: INCOME**

**Please check the appropriate boxes if anyone age 18 and older receives any of the following income.** Please include documentation to support any income checked for OCCUPANTS only. For payroll, please attach two of the following: W2 (most recent), tax return (most recent), pay stubs (3 current), or bank statement (3-month period). For all other sources of income received, please attach a payment statement.

INCOME*	INDIVIDUAL RECEIVING	GROSS MONTHLY AMOUNT
Payroll	:	\$
Payroll	:	\$
Unemployment Compensation	:	\$
Disability Compensation	:	\$
Worker's Compensation	:	\$
Child Support	:	\$
Alimony	:	\$
Severance Pay	:	\$
DHS Cash Assistance	:	\$
Supplemental Security Income (SSI)	:	\$
Annuity or retirement	:	\$
Pension	:	\$
Other	:	\$

**\*If you checked any of the above, please provide documentation. Documents sent will not be returned. Please submit copies only.**

**PART 7: SIGNATURE**

*By signing below, 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	Property Owner Signature	Date
Print Tenant Name (if applicable)	Tenant Signature (if applicable)	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, 4<sup>th</sup> Floor  
 P.O. Box 30195  
 Lansing, MI 48909

517-284-1018 (Main), TTY users call 711, 517-335-6146 (Fax),  
[MDHHS-ComplianceOffice@michigan.gov](mailto: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 <a href="https://bit.ly/2pBS4YG">https://bit.ly/2pBS4YG</a>, 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 <a href="https://bit.ly/2IKsHMS">https://bit.ly/2IKsHMS</a>.</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: <a href="https://bit.ly/2g9zzpU">https://bit.ly/2g9zzpU</a> 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: <a href="mailto:program.intake@usda.gov">program.intake@usda.gov</a></p>
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MDHHS is an equal opportunity provider.