Michigan Department of Health and Human Services (MDHHS)

Please note if needed, free language assistance services are available.

Call 517-335-9390 (TTY users call 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 517-335-9390 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 517-335-9390 (رقم هاتف الصم والبكم:-711:TTY).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 517-335-9390（TTY:711）
Syriac (Assyrian)	ܫܡܘܥܬܐ: ܐܝ ܐܢ ܐܢܬ ܡܗܝܡܢ ܒܠܫܢܐ ܐܬܘܪܝܐ، ܐܝܟ ܒܗ ܕܡܝܢ ܫܘܬܦ ܐܝܬ ܠܟ ܫܝܪܘܬ ܕܥܙܪܐ ܒܠܫܢܐ ܕܝܠܟ ܒܚܠܦ ܡܬܐ. ܩܠ ܠ 517-335-9390 (TTY:711)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 517-335-9390 (TTY:711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 517-335-9390 (TTY:711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 517-335-9390 (TTY:711)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-517-335-9390 (TTY ১-711)
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 517-335-9390 (TTY:711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 517-335-9390 (TTY:711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 517-335-9390 (TTY:711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。517-335-9390（TTY:711）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 517-335-9390 (телетайп 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 517-335-9390 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 517-335-9390 (TTY: 711).

MDHHS-Lead Services Section
PO Box 30195, 3rd floor, Lansing, MI 48909
Michigan.gov/MiLeadSafe
MDHHS-LeadApps@michigan.gov
Ph: 517-335-9390
Fx: 517-284-9956

APPLICATION FOR

Lead Services

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 (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
	/ /		Select		Select		Select	Select race
	/ /		Select		Select		Select	Select race
	/ /		Select		Select		Select	Select race
	/ /		Select		Select		Select	Select race
	/ /		Select		Select		Select	Select race
	/ /		Select		Select		Select	Select race
	/ /		Select		Select		Select	Select race
	/ /		Select		Select		Select	Select race
	/ /		Select		Select		Select	Select race
	/ /		Select		Select		Select	Select race
Visiting Children First & Last Name (only list children under 6 years of age)	**DOB**		***BLL?**	**How long does the child visit?** Hours/day? Days/week? Weeks/year?			**Ethnicity**	**Race**
	/ /		Select				Select	Select race
	/ /		Select				Select	Select race
	/ /		Select				Select	Select race
	/ /		Select				Select	Select race
	/ /		Select				Select	Select race
	/ /		Select				Select	Select race

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?		○	○	○	○

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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, 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.

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: 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) Complaint forms are available at https://bit.ly/2IKsHMS.	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: 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. 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 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.