ILENE SHAPIRO
COUNTY EXECUTIVE

County of Summit
Lead Hazard Reduction
Owner Occupied Application

About the Program

The County of Summit Lead Hazard Reduction Program (SCLHR) is not an emergency program. Homes must be located in the County of Summit, Ohio.

Homeowners 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 home or visits at least 6 hours per week (at least 60 hours per year).
- The home meets local ordinances and housing codes.
- The home is free of clutter, insects, rodents, and unsanitary conditions.
- Property taxes are not delinquent.
- Must have current homeowners' insurance

How the program works after the application is approved: *timeline may vary for each applicant

Phase 1: Inspections & Scope of Work

- Initial Assessments: A Summit County Public Health (SCPH) Lead Risk Assessor will contact you to schedule a Lead Inspection/Risk Assessment (LIRA) and a Healthy Homes (HH) Assessment. You will receive the LIRA and HH reports by mail, which will list all identified lead hazards.
- Radon Testing: A program-registered radon tester will contact you to conduct a radon test.
- Scope of Work (SOW): The program will create a SOW to address lead and HH hazards using a fixed- cost pricing model. Once a contractor is assigned and the project is reviewed, you will receive a final SOW to sign.

Phase 2: Financing, Mortgages, & Insurance

- The County of Summit will schedule an in-person meeting for you to sign your mortgage documents and sign the access agreement.
- How Your Funding Works: A deferred, forgivable loan (Mortgage) secures 50% of the project cost. This is a five year, deferred, forgivable loan. The Program pays for the final 50% of the remaining project cost as a grant to the owner.
- Mortgage Terms: The loan is a deferred, forgivable loan which is forgiven by 20% each year on the anniversary of the mortgage document recording. However, the pro-rated loan balance becomes due if, within 5 years, the home is sold, transferred, the owner passes away, or is no longer your primary residence.

EQUAL HOUSING LENDER

- Insurance: You must add the County of Summit as an "Additional Insured" on your homeowners' insurance policy for the 5-year loan term (documentation required prior to closing).
- Taxes: Property taxes must be current and remain current for the term of the loan.

Phase 3: Preparing the Home

- Home Conditions: Lead work will not begin if the home is cluttered, unsanitary, or infested with pests.
- Pest Control: The program does not pay for pest extermination. If needed, you must hire pest control operator licensed by Ohio Department of Agriculture and provide proof to SCPH.
- Pre-Work Meeting: Before relocating, you will meet with program staff to sign an access agreement that reviews the terms of relocation, and exactly which household items must be moved before construction starts.

Phase 4: Relocation and Hotel Rules

- You are required to relocate while lead work is being completed. You are highly encouraged to stay with friends or family. If that is not possible, you must provide a hardship letter at your loan closing to qualify for a hotel stay.

Hotel & Amenity Rules:

- SCPH will select and pay for a hotel with a kitchenette. The program will not pay for food.
- The program will not pay for or provide any transportation
- You must provide a debit or credit card at check-in for any incidentals.
- Only individuals listed on the program application as residents may stay at the hotel or use the hotel amenities (like the pool). No additional guests are allowed.
- Failure to follow hotel policies may result in the loss of your reservation, and SCPH will not make alternative arrangements.
- You must notify SCPH of any pets going to the hotel before reservations are made. The program does not cover pet boarding costs. No animals may be left inside or outside the home. If animals are left behind, Animal Control will be called to remove them, and you will be responsible for all retrieval fees.

Phase 5: During the Lead Work

- Strict No-Entry Policy: Once work begins, only program staff and contractors are permitted to enter the home. Unauthorized re-entry will stop work and may result in an invoice for all work done and materials ordered being sent to the client for payment.
- Clearance: You may not return to the property until the work is completely finished, the home passes a clearance inspection.
- Notification: SCPH staff will contact you directly to let you know when it is safe to return home

EQUAL HOUSING LENDER

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 (SCPH) or 330-643-2537 (SCDOD) 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 Applicant Date

_____ _____

Signature of Co-Applicant Date

This section intentionally left blank

EQUAL HOUSING LENDER

Mail: **County of Summit LEAD**
175 S. Main Street, Room 207
Akron, Ohio 44308
E-mail: DODapplications@summitoh.net
(Must be PDF format)

County of Summit
HUD Lead-Based Paint Hazard Reduction Program
Owner Occupied Application

Required Documents

The following documents will be needed for all adults in the household at the time of your application review as they pertain to your household:

- ☐ Proof of identity (current Photo or State ID, birth certificate, and social security card) for all household members and children who spend more than 6 hours per week in the home
- ☐ Notarized affidavit from parent/ guardian that the visiting child spends more than 6 hours per week in the home
- ☐ A copy of your (6) most recent pay stubs
- ☐ A copy of your Social Security Benefits Statements (Form SSA-1099) 2025 and 2026 SSI & SSDI award letter(s)
- ☐ A copy of your current monthly pension statement
- ☐ A copy of your 2025 W-2 Statement of Earnings or 1099 Statement
- ☐ A copy of your 2025 Federal 1040 Tax Return or if you do not file federal taxes a notarized statement indicating why taxes are not filed
- ☐ Notarized letter signed and dated for every person living in the home over aged 18 years with no income
- ☐ A copy of your complete divorce documents/decree
- ☐ A copy of bankruptcy discharge (only if occurring before the five-year limit)
- ☐ Copies of your last 3 months' bank statements for all checking/savings accounts
- ☐ If any adult in the household is a full-time student, the class schedule must be provided with the student's and school's names visible
- ☐ A copy of your current homeowner's insurance listing address

NOTE: Not all the above documents pertain to your personal situation. Please provide ONLY the documents that apply to you. If you are married, the above information will be required for all individuals applying. Additional information may be requested as your application is in the review process. The application review process may take up to 30 days.

INCOME LIMITS - Community and Economic Development								
% AMI	1 Person	2 People	3 People	4 People	5 People	6 People	7 People	8 People
80%	$54,400	$62,200	$69,950	$77,700	$83,950	$90,150	$96,350	$102,600

*Income Limits Subject to Change *Revised effective 5/1/2026

EQUAL HOUSING LENDER

Mail: **County of Summit LEAD**
175 S. Main Street, Room 207
Akron, Ohio 44308
E-mail:DODapplications@summitoh.net
(Must be PDF format)

County of Summit
HUD Lead-Based Paint Hazard Reduction Program
Owner Occupied Application

All sections of the Application must be completed. Indicate "N/A" if it does not apply to you.
Incomplete applications may be denied.

Part 1 – Applicant Information

Name: _____

Address: _____ City, State, Zip code _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

☐ Co-Applicant ☐ If no Co-Applicant please check here

Name: _____

Address: _____City, State, Zip code _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

This section intentionally left blank

Part 2 – Household Composition

Name		**Relationship to you**	Self
DOB		**Race**	☐ American Indian/Alaskan Native ☐ Am. Indian/Alaskan Native/Black ☐ Am. Indian/Alaskan Native/White ☐ Asian ☐ Asian/White ☐ Black/African American ☐ Black/African American/White ☐ Native Hawaiian/Pacific Islander ☐ Other multi-racial ☐ White
SSN			
Primary Language			
Gender	☐ Male ☐ Female		
Marital Status	☐ Married ☐ Divorced ☐ Widowed ☐ Single		
Disabled	☐ Yes ☐ No		
Military Status	☐ Active Duty ☐ Veteran ☐ No Status		
Level of Education		**Ethnicity**	☐ Hispanic ☐ Not Hispanic
		Citizenship	☐ U.S. Citizen ☐ Legal Resident

Name		**Relationship to you**	
DOB		**Race**	☐ American Indian/Alaskan Native ☐ Am. Indian/Alaskan Native/Black ☐ Am. Indian/Alaskan Native/White ☐ Asian ☐ Asian/White ☐ Black/African American ☐ Black/African American/White ☐ Native Hawaiian/Pacific Islander ☐ Other multi-racial ☐ White
SSN			
Primary Language			
Gender	☐ Male ☐ Female		
Marital Status	☐ Married ☐ Divorced ☐ Widowed ☐ Single		
Disabled	☐ Yes ☐ No		
Military Status	☐ Active Duty ☐ Veteran ☐ No Status		
Level of Education		**Ethnicity**	☐ Hispanic ☐ Not Hispanic
		Citizenship	☐ U.S. Citizen ☐ Legal Resident

EQUAL HOUSING LENDER

Name		Relationship to you	
DOB		Race	☐ American Indian/Alaskan Native ☐ Am. Indian/Alaskan Native/Black ☐ Am. Indian/Alaskan Native/White ☐ Asian ☐ Asian/White ☐ Black/African American ☐ Black/African American/White ☐ Native Hawaiian/Pacific Islander ☐ Other multi-racial ☐ White
SSN			
Primary Language			
Gender	☐ Male ☐ Female		
Marital Status	☐ Married ☐ Divorced ☐ Widowed ☐ Single		
Disabled	☐ Yes ☐ No		
Military Status	☐ Active Duty ☐ Veteran ☐ No Status		
Level of Education		Ethnicity	☐ Hispanic ☐ Not Hispanic
		Citizenship	☐ U.S. Citizen ☐ Legal Resident

Name		Relationship to you	
DOB		Race	☐ American Indian/Alaskan Native ☐ Am. Indian/Alaskan Native/Black ☐ Am. Indian/Alaskan Native/White ☐ Asian ☐ Asian/White ☐ Black/African American ☐ Black/African American/White ☐ Native Hawaiian/Pacific Islander ☐ Other multi-racial ☐ White
SSN			
Primary Language			
Gender	☐ Male ☐ Female		
Marital Status	☐ Married ☐ Divorced ☐ Widowed ☐ Single		
Disabled	☐ Yes ☐ No		
Military Status	☐ Active Duty ☐ Veteran ☐ No Status		
Level of Education		Ethnicity	☐ Hispanic ☐ Not Hispanic
		Citizenship	☐ U.S. Citizen ☐ Legal Resident

Note: If more space is needed for household members, please write out on separate sheet of paper.

This section intentionally left blank

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All Household Income Source(s)check all that apply. ***Documentation must be provided.***

☐Active Military Pay	☐DA (Disability Assistance)	☐Employment
☐Interest	☐Inheritance	☐Pension
☐Self-Employment	☐SSDI	☐SSI
☐Social Security	☐TANF/ADC	☐Unemployment
☐Utility Allowance	☐VA Disability	☐VA Pension
☐Wages	☐Workers' Compensation	☐Other: _____

Part 3 - Income verifications

Attach proof of income for all household residents 18 years and older. Failure to provide the required income documents will delay the processing of your application. Individuals 18 or older claiming zero income must provide a notarized explanation on a separate sheet.

Applicant - please list your employer(s) and income ☐ Check here if you are unemployed

Employer(s)		**Amount of Paycheck (Monthly Gross, Before Taxes)**
Current		
2025		

Other Sources of Income			**Total Amount Per Month**	
	Yes	**No**	**Current**	**2025**
Child Support	☐	☐		
Alimony	☐	☐		
Pension	☐	☐		
Social Security or SSI	☐	☐		
Disability Benefits	☐	☐		
Unemployment Benefits	☐	☐		
Do you have other income?	☐	☐	**If yes, please write a page listing the income and return it with the Application.**	

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EQUAL HOUSING LENDER

Co-Applicant - please list your employer(s) and income ☐ Check here if you are unemployed

Employer(s)		**Amount of Paycheck (Monthly Gross, Before Taxes)**
Current		
2025		

Other Sources of Income			**Total Amount Per Month**	
	Yes	**No**	**Current**	**2025**
Child Support	☐	☐		
Alimony	☐	☐		
Pension	☐	☐		
Social Security or SSI	☐	☐		
Disability Benefits	☐	☐		
Unemployment Benefits	☐	☐		
Do you have other income?	☐	☐	**If yes, please write a page listing the income and return it with the Application.**	

Part 4 – Emergency Contact (at least one must be provided)

Name: _____	Name: _____
Phone Number: _____	Phone Number: _____
Relationship: _____	Relationship: _____

Do you care for children younger than 6 years of age in your home? ☐Yes ☐No
If yes, fill in the next section.

Child's name	Date of Birth	Hours per day	Days per week

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Part 5 – Assets

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

☐ Check here if you have no bank accounts

Name of Bank or Credit Union	Type of Account (Checking/Savings)	Current Balance
		$
		$
		$

<u>Stocks, Bonds, Certificates of Deposit, Securities, IRA's, Etc.</u>

List all current accounts. **Any funds drawn from the account will be counted as income.**

☐ Check here if you have none of these accounts

Description (Name of stock, money market account, government bond, etc.)	Approximate Value
	$
	$
	$

Part 6 – Mortgage Information

You must answer all the questions. If something does not apply to you, answer N/A.

Is your home paid in full? ☐ Yes ☐ No

Do you have a reverse mortgage? ☐ Yes ☐ No

List all mortgages on the property:

Bank /Lending Institution	Original Mortgage Amount	Current Mortgage Balance	Monthly Payment	Type of Loan**

**For the type of loan, please indicate whether it is: FHA, VA, Conventional, or Land Contract

Do you reside in the home all 12 months of the year? ☐ Yes ☐No

Do you use your property for business purposes? ☐ Yes ☐No

If yes, please describe the business: _____

_____

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Other Real Estate Owned or Co-Owned

(List all current real estate owned other than primary residence. Rent payments are considered income)

☐ Check here if you have no other owned or co-owned real estate

Description (Rental property, vacation home, etc.)	Address	Monthly Rent
		$
		$

APPLICANT CERTIFICATION AND AUTHORIZATION

I/We hereby certify under penalty of perjury that all information provided in this application, including but not limited to household composition, income, and assets, is true, accurate, and complete to the best of my/our knowledge and belief.

I/We understand that this information is being collected to determine my/our eligibility for federal financial assistance through the Summit County Lead Hazard Reduction grant program. I/We authorize The County of Summit and/or Summit County Public Health to verify any and all information contained in this application, which may include obtaining documentation from third-party sources.

I/We acknowledge that providing false, fictitious, or fraudulent information, or omitting material information, is a federal offense. I/We understand that any such false statements may result in the immediate denial of this application, termination from the program, a requirement to repay any grant funds expended on my/our behalf, and may be subject to administrative, civil, or criminal penalties, including fines and imprisonment under Title 18, Section 1001 of the United States Code.

Signature of Applicant _____ Date _____

Signature of Co-Applicant _____ Date _____

EQUAL HOUSING LENDER

Part 7 – Conditions

The Applicant(s) agree that the presence of hazardous conditions may disqualify and exclude their housing unit from eligibility for participation in the SCLHR Program and affirm that their housing unit is free of:

- Infestation by rats, mice, or other vermin;
- Infestation by fleas, lice, or other insects;
- No animal waste inside the home;
- Cluttered debris or stored materials suitable for rodent or insect habitat; and
- Visible mold or mildew.

I/we affirm that my/our housing unit is free of the above-listed hazards and further affirm that I/we understand that the presence of any of the above-listed hazards may disqualify and exclude my/our housing unit from eligibility for participation in the SCLHR Program.

The Applicant(s) acknowledge that County of Summit Department of Community and Economic Development staff reserve the right to determine if the dollar amount needed to rehabilitate my/our housing unit exceeds the maximum amount allowed per project and that this may disqualify and exclude my/our housing unit from eligibility for participation in the SCLHR Program. The Applicant(s) also acknowledges that repairs through this program will only address health and safety concerns, not aesthetics.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Co-Applicant Date

This section intentionally left blank

EQUAL HOUSING LENDER

Part 8 – Certifications

The Applicant(s) certify that they are the legal owner of the property listed in this application and that the rehabilitation loan will be used only for work and materials necessary to meet the rehabilitation or building code standards, as applicable, and which are recommended for the property in this application. If the program determines the cost of rehabilitation exceeds the maximum amount per program guidelines, no state or federal funds will be invested in the property, and the application will be closed. The Applicant(s) acknowledge(s) and agree(s) that they have no interest, right, or claim with respect to said funds and that the County of Summit will not be liable for any costs or expenses incurred if the Applicant(s) does not receive such funds.

The Applicant(s) also certifies that:

- They understand that submittal of an application is not a guarantee of funding, and that income eligibility, the condition of the property, and the work scope determined necessary by the program will be used to determine eligibility.
- They will use the property in a lawful manner with regard to occupancy, zoning ordinances, and property maintenance codes.
- They understand that the main objective of the program is to correct safety and health issues and/or code violations within the home and that funds will be used to address these items prior to any other repairs being made.

The Applicant(s) further acknowledge(s) that any verbal or physical abuse or threats of the program staff, contractors, or their employees may result in the immediate termination of assistance and that any work performed will be at the Applicant's expense.
The Applicant(s) covenants and agrees that they will comply with all local, state, and federal laws, including, but not limited to all requirements imposed pursuant to regulations of the Secretary of Housing and Urban Development effectuating Title VI of the Civil Rights Act of 1964 (78 Stat. 252). The Applicant(s) agrees not to discriminate upon the basis of race, color, creed, age, sex, gender identity, sexual orientation, and/or national origin. The United States shall be a beneficiary of these provisions both for and in its own right, and also for the purpose of protecting the interests of the community and other parties, public or private, in whose favor or for whose benefit these provisions have been provided and shall have the right, in the event of any breach of these provisions, to maintain any actions or suits at law or in equity or any other proper proceedings to enforce the curing of such breach.

WARNING: Section 1001 of Title 18 of the United States Code makes it 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.

Signature of Applicant	Date
Signature of Co-Applicant	Date

EQUAL HOUSING LENDER

Part 9 – Walk Away Policy/Application Closure

Regardless of eligibility, under certain circumstances, an applicant may not receive assistance through the County of Summit Department of Community and Economic Development. Such circumstances include, but are not limited to:

- The homeowner, applicant, or any occupant becomes verbally or physically abusive and/or threatens staff members.
- During the course of the work the owner and/or occupants continually fail to cooperate with staff or contractors
- The 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.
- The work scope is larger than what the program can cover.
- Failure on the part of the applicant/owner to demonstrate pride of ownership. Conditions included under pride of ownership include, but are not limited to:
    - Abuse of animals: evidence of unsanitary conditions or Illegal or improper use of the property
    - Housekeeping and maintenance: extreme conditions of clutter or filth in or around the house
- Failure to return phone calls to County staff or contractors in a timely manner.
- Failure to allow contractor(s) to complete work in a timely manner
- Failure to have an adult in the home while County staff and/or contractors are present.
- Failure to allow final inspections from County staff and/or contractors.

Under any of the circumstances, assistance may be withheld and/or terminated at the discretion of the County of Summit Department of Community and Economic Development.

Any work that may have been completed prior to a violation of any of the above items will be invoiced to the client and due immediately.

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

_____ _____

Signature of Applicant Date

_____ _____

Signature of Co-Applicant Date

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Part 10 – Consent to Participate in the Unite Us Network

By consenting, you agree to share information with a Network of health and social service partners powered by Unite Us software. This Network is made up of entities and individuals who are directly involved in your care or payment of care. Your personal information may be shared securely on the Network in accordance with privacy laws to connect you with services.

This consent covers all information shared by you or by anyone who has the right to share information on your behalf and is relevant to the recipient's involvement in your care or payment for your care. You can always limit the information you provide on the Network by requesting to have it removed.

To understand how your information may be used and kept safe on the Network, please see uniteus.com/privacy.

If you no longer want your information shared on the Network, you can email consent@uniteus.com or ask any Network partner.

Consent

Client Name: _____ Birthdate: _____

Signature: _____ Date: _____

Personal Representative or Guardian (only if applicable)

Name:_____ Relationship to Client: _____

Signature: _____ Date: _____

Contact Preferences (You may select more than one)

Email: _____

Text: _____

Phone: _____

EQUAL HOUSING LENDER

Part 11 – Multi-Party Authorization for Release of Information

Please read the instructions carefully. Enter the information completely. Include all child(ren) under the age of 6 who live in the home or visits on a regular basis (at least 60 hours per year) include the names, dates of birth, relationships.

Failure to provide the required income documents will delay the processing of your application.

I, _____ hereby authorize the Summit Combined General Health District to:

☐ Release or ☐ Obtain information for the child(ren) listed below:

Child/Patient(s) Name	Date of Birth	Relationship to you
Obtain Information from:		
Agency: Summit County Department of Community Development	**Purpose:** Determine eligibility	

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. 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 (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 Parent/Guardian of Child(ren) Date

EQUAL HOUSING LENDER

Authorization
for
Lead Inspection and Radon Testing

This Authorization is made as of _____ by _____ (hereinafter the "Client") to permit the County of Summit, Ohio, an Ohio charter county and political subdivision, with an address at the Executive's Office, 175 S. Main Street, 8th Floor, Akron, Ohio 44308 (hereinafter the "County") and Summit County Combined General Health District, aka Summit County Public Health ("SCPH") to conduct a Lead Inspection Risk Assessment and Short-Term Radon Test at _____ (hereinafter the "Property").

1. Lead Inspection Risk Assessment

Client agrees to permit the County to conduct a Lead Inspection Risk Assessment at the Property. The Assessment is a comprehensive evaluation performed by a licensed lead inspector to identify the presence of lead-based paint and lead hazards in the property. The assessment includes:

- Visual inspection of the interior and exterior of the property for potential lead-based paint hazards.
- Testing of paint, dust, soil, or other surfaces using approved methods, such as X-ray fluorescence (XRF) or laboratory analysis.
- A detailed report outlining findings, including the location and condition of any lead hazards, and recommendations for mitigation, if applicable.
- The Client acknowledges that the Lead Inspection Risk Assessment is conducted in accordance with Ohio Department of Health and Federal Department of Housing and Urban Development regulations. The results are intended to identify lead hazards in the home. The Client agrees that if the home is currently part of a Public Health Lead Investigation, the home will be subject to Lead Hazard Control Orders (LHCO) if lead hazards are identified.

2. Short-Term Radon Test

Client agrees to permit the County to conduct a Short-Term Radon Test at the Property. The Short-Term Radon Test will be conducted by a licensed radon tester in accordance with Ohio Department of Health Regulations (Ohio Administrative Code Chapter 3701-69). The test involves the placement of radon measurement devices in the property for a period of 48-96 hours to measure radon levels.

3. Occupant Responsibilities for Radon Testing

- To ensure accurate results, the Client agrees to adhere to the following testing requirements:
- **Closed-House Conditions**: Maintain closed-house conditions for at least 12 hours prior to and during the entire testing period. This includes keeping all windows and exterior doors closed, except for normal entry and exit.
- **No Interference**: Do not tamper with, move, or disturb the radon testing devices during the testing period.

- **Environmental Controls**: Avoid operating fans, air purifiers, or other devices that may alter air circulation, unless they are part of the property's permanent HVAC system.
- **Access**: Provide the licensed radon tester with reasonable access to the property to place and retrieve testing devices.

Failure to comply with these requirements may result in invalid test results. If the test is invalidated due to non-compliance, the Client will be responsible for the cost of any subsequent testing required to obtain valid results. The cost for additional testing is $200.00.

4. Hold Harmless

The Client agrees to hold harmless and release the County and SCPH, its employees, agents, and contractors from any and all claims, damages, losses, liabilities, or expenses (including reasonable attorney fees) arising from or related to:

- The performance of the Lead Inspection Risk Assessment and/or Short-Term Radon Test, provided they are conducted in accordance with applicable Ohio regulations.
- Any health effects, property damage, or other consequences resulting from the presence of lead or radon at the property, as the County's or SCPH's role is limited to identifying and reporting hazards.
- The Client's failure to adhere to the radon testing requirements outlined in Section
- 2.1, including any costs associated with re-testing due to non-compliance.

Acknowledgment and Authorization

By signing below, the Client acknowledges that they:

- Understand the nature and purpose of the Lead Inspection Risk Assessment and Short-Term Radon Test.
- Agree to comply with the radon testing requirements to ensure accurate results.
- Understand that failure to comply with radon testing requirements may result in additional testing costs.
- Have had the opportunity to ask questions and receive clarification about the inspection and testing processes.

Applicant Signature: _____ Date: _____

Co-Applicant Signature: _____ Date: _____

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Only complete if Federal taxes are not filed

Affidavit for not filing federal taxes

I, _____, did not file federal taxes in **2025** because I was

(Print name)

Check one:

☐ No longer required to file

☐ A full-time student

☐ Unemployed

Print name: _____

Signature: _____ Date: _____

Address: _____

(Street) (City) (State) (Zip)

State of Ohio

County of _____

The foregoing instrument was acknowledged before me on _____

(Date)

by _____

(Name of person acknowledged)

_____ _____

Notary Public Print Name Notary Public Signature

_____ Affix Notary Seal

My commission expires (date)

Summit County
Public Health

1867 W. Market St. Akron, OH 44313
330-923-4891
www.scph.org

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how 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.

Get an electronic or paper copy of your medical record	· 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. · 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.
Ask us to correct your medical record	· You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. · We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	· 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. · We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	· You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  · We are not required to agree to your request, and we may say "no" if it would affect your care.
	· 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.
	  · We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	· 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. · 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.
Get a copy of this privacy notice	· You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	· 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. · We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	· You can complain if you feel we have violated your rights by contacting us using the information on page 1. · 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 **www.hhs.gov/ocr/privacy/hipaa/complaints/**. · We will not retaliate against you for filing a complaint.

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.

In these cases, you have both the right and choice to tell us to:	· Share information with your family, close friends, or others involved in your care · Share information in a disaster relief situation · Include your information in a hospital directory · Contact you for fundraising efforts *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.*
In these cases we *never* share your information unless you give us written permission:	· Marketing purposes · Sale of your information · Most sharing of psychotherapy notes
In the case of fundraising:	· We may contact you for fundraising efforts, but you can tell us not to contact you again.

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.

Treat you	· We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	· We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
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.**

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 aboutyou: · 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.

The Confidentiality of Alcohol and Drug Abuse Patient Records. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

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(1) The patient consents in writing:

(2) The disclosure is allowed by a court order; or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. The local SAMHSA Office can be reached at 614-466- 2596 and the local US Attorney General's Office can be reached at 330-375-5716. You may also reach SAMHSA at 1- 877-726-4727.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.)

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.**

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: 7/2024

For questions, please contact the Summit County Public Health Privacy Officer by calling 330-923-4891 or email privacy@scph.org.