CITY OF MILWAUKEE
HEALTH DEPARTMENT

CDBG Milwaukee

Lead Hazard Reduction Assistance Application: Occupant Checklist

Date: _____ Occupant Name: _____ Phone: _____
Address: _____ Unit #: _____
City: _____ State: ____ Zip Code: _____ Email: _____

*All of the documents listed below must be returned with this checklist **WITHIN 30 DAYS** to complete your application.*

THE FOLLOWING DOCUMENTS ARE REQUIRED FROM ALL OCCUPANTS 18 YEARS OR OLDER THAT LIVE IN THE UNIT:

☐ **Lead Hazard Reduction Assistance Application: Occupant Worksheet (H-3014 B)**
(Occupant or Owner-Occupant completes the entire application.)

☐ **Consent and Authorization to Release Confidential Information (H-3014 C)**
(Occupant: Consent and authorization form to disclose and use confidential information.)

☐ **Employment Verification Sheet (H-3014 D)**
(Occupant: Please have your employer complete and sign this form, then submit with completed application.)

☐ **Blood Lead Testing Acknowledgment**
(Occupant: Consent or non-consent for blood testing.)

☐ **Relocation Hardship Questionnaire**
(Occupant: Relocation needs assessment.)

☐ **Income Verification Forms**
(Occupant or Owner, if Owner-Occupied.)

- ☐ Bank Statements (Last 3 months) (Chime, Cashapp, etc.)
- ☐ Foodshare and other Benefit Letters (SSI, SSA ETC.)
- ☐ Pay Stubs (Last 3 months- total of 12 if paid weekly; a total of 6 if paid bi-weekly)
- ☐ Previous Year's Filed Federal Tax Return
- ☐ Notarized Statement of unemployment, self-employment and unavailable requested documents
- ☐ Picture ID of Head of Household

PLEASE BE SURE THAT DOCUMENTS FOR ALL OCCUPANTS 18 AND OLDER ARE SUBMITTED.
APPLICATIONS CANNOT BE PROCESSED UNTIL ALL DOCUMENTS ARE RECEIVED.

Documents can be submitted by:

Email:
leadenrollment@milwaukee.gov

Fax:
414-286-0382

Mail or drop off:
Home Environmental Health
841 North Broadway, First Floor, Suite 118
Milwaukee, WI 53202

Lead Hazard Reduction Assistance Application: Occupant Worksheet (H-3014 B)

Property Address	Unit #		
Rental check box -	☐ Yes	☐ No	☐ Unknown
Owner-Occupied check box -	☐ Yes	☐ No	☐ Unknown
Is there a child under the age of 6 living in the house full time? If yes, how many?___________	☐ Yes	☐ No	☐ Unknown
Is there a child under the age of 6 who is a regular visitor (for at least 6 hours per week, 10 weeks per year)? If yes, how many? ___________	☐ Yes	☐ No	☐ Unknown
Is there a child under 6 living in or a regular visitor to this home with a blood lead level of 5 or higher? If yes, how many? ___________	☐ Yes	☐ No	☐ Unknown
I understand that children under 6 years old who live in my house or regularly visit my house must be tested for lead in order for the property to be eligible for lead abatement assistance. *(If not tested within 90 days before the project is started, city will provide free testing.)*	☐ Yes	☐ No	☐ Does not apply
Is this home being used as an in-home child care? If so, how many children attend? ____________	☐ Yes	☐ No	☐ Unknown
Is there a pregnant person living in the house full time?	☐ Yes	☐ No	☐ Unknown
Is there a pregnant person who is a regular visitor (for at least six hours per week, 10 weeks per year)?	☐ Yes	☐ No	☐ Unknown
I understand that any pregnant person living in the house, or who is a regular visitor to the house, must be tested for lead in order for the property to be eligible for lead abatement assistance. *(If not tested within 90 days before the project is started, city will provide free testing.)*	☐ Yes	☐ No	☐ Does not apply
Note: In order to qualify for lead abatement assistance, there must be a child under the age of 6 living in or regularly visiting the home, or a pregnant woman living in or regularly visiting the home.			

A. Number of occupants who live in household:	B. Number of children under 6 and/or number of pregnant people who live or spend significant time in the home:	
Answer the following for the Head of Household		
Gender: ☐ Male ☐ Female ☐ Other:	Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Multi-Race	Ethnicity: ☐ Hispanic ☐ Not Hispanic

List everyone who lives at the property (number should equal number listed in box A). Attach additional sheets if necessary.

Name	Has a disability?	Receiving Public Assistance?	Date of Birth	Relationship to Head of Household	Employed?	Yearly Income (if employed)
	☐ Yes ☐ No	☐ Yes ☐ No		*Head of household*	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	

Occupant Worksheet, cont.

All Occupants, adult and children, must be listed and information complete.

- This program **highly recommends** that all children under 6 years old or pregnant women who live or spend a significant amount of time in the home be tested for blood lead poisoning in the 90 days **before** work is done on your home. Contact your doctor or the health department to arrange for blood tests. This information will be treated as confidential. Documentation of lead testing is needed in order to associate a child with a household. The City will provide the testing free of cost to you.
- Homes with children under 6 years of age (birth to 5) with an Elevated Blood Lead (EBL) level will be given higher priority.
- Proof of income should be listed for all those who are 18 years of age and older within the household Current pay stub (within one month), bank statements, prior year tax returns – if self-employed, will need tax returns for prior two years. Zero income individuals require a notarized statement.

I acknowledge that I have been given brief instruction regarding my responsibilities during this work process. They are as follows:

- All children and pregnant people must be out of the house/apartment each day and night while interior work is being done. Occupants can be in their home during exterior work.
- The house/apartment must be clean and orderly before work begins. An inspection will be allowed prior to work, if this is requested by the City of Milwaukee Health Department.
- If window replacement is being done,
  - All furniture will be moved away from the windows before the contractor arrives.
  - All window curtains/shades or mini-blinds and hardware will be removed before the contractor arrives on the job, and will be replaced by the occupant when work is complete.
- Children and pregnant people may not be present while any interior work is being done by the contractor this is to protect them from being exposed to lead.
- If significant work is being completed, there may be the option of temporary relocation assistance. Such requests must be reviewed and approved by a health department manager prior to work commencing.

I accept the responsibilities and obligations listed above and certify that the information below is accurate. I understand that I shall be notified at least 48 hours in advance of any work being done on this project.

Head of Household's Signature _____ **Date**_____

CITY OF MILWAUKEE
HEALTH DEPARTMENT

Blood Lead Testing Acknowledgment -Consent or Nonconsent Form

Program Name: Lead Hazard Reduction Program

To help protect children's health, it is recommended that all children under six (6) years of age living in or regularly visiting the home have a blood lead level test before lead hazard control begins.

If your child has not had a blood lead test within the past three (3) months), please contact your child's healthcare provider or your local health department to schedule a test.

* **Please list all children under the age of 6**

Child 1

- Name of Child: _____
- Child's Date of Birth: _____
- Healthcare Provider/Clinic: _____
- Has had a Blood Test in past three 3 Months

  ☐ Yes Date of Test: _____
  ☐ No, but I agree to have them tested
  ☐ For personal and/or religious reasons, I decline blood lead testing for my child

Child 2

- Name of Child: _____
- Child's Date of Birth: _____
- Healthcare Provider/Clinic: _____
- Has had a Blood Test in past three 3 Months

  ☐ Yes Date of Test: _____
  ☐ No, but I agree to have them tested
  ☐ For personal and/or religious reasons, I decline blood lead testing for my child

Child 3

- Name of Child: _____
- Child's Date of Birth: _____
- Healthcare Provider/Clinic: _____
- Has had a Blood Test in past three 3 Months

  ☐ Yes Date of Test: _____
  ☐ No, but I agree to have them tested
  ☐ For personal and/or religious reasons, I decline blood lead testing for my child

*If you have additional children under six (6) years of age, please list them on an additional page

☐ **I authorize the healthcare provider(s) listed above to release my child(ren)'s blood lead test results to the Lead Hazard Reduction Grant Program for program purposes.**

Acknowledgment

I/We voluntarily provide the information contained in this form. I/We understand that providing this information is voluntary and that disclosure of this information is not required to participate in the Lead Hazard Reduction Program, unless otherwise required by applicable law or program requirements.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____

Date: _____

Program Use Only

Date Received: _____

Received By: _____

City of Milwaukee Health Department

Lead Hazard Reduction Assistance Application: Occupant Worksheet (H-3014 B Supplement)

Relocation Needs Assessment

Property Address:		Unit #
Number of Units:	Company Name: *(if applicable)*	
Owner's First Name:	Owner's Last Name:	
Owner's Address: *(write "same" if Owner-Occupied)*		
Owner's Primary Phone:	Owner's Secondary Phone:	
Best time to be reached? *(Between 7 am-4 pm M-F)*:	Owner's Email:	
Primary Contact *(if other than the owner)*:	Primary Contact's Phone:	

Occupant Name:	Phone:	Email:

Relocation is often necessary for Lead Hazard Reduction Activities. Please answer the following questions about relocation.

Do you have a place to stay while this work is being performed in your home?
If so, how long could you stay there?
Is the residence lead safe?
How many people would need to be relocated?
Would any pets need to be relocated?

CITY OF MILWAUKEE
HEALTH DEPARTMENT

Relocation Hardship Questionnaire

Instructions
Please complete this questionnaire by describing your current financial and housing situation and any circumstances that may make relocating difficult. Your responses will be used to determine whether you qualify for relocation assistance. Answer each question honestly and provide additional details where requested.

1. Are you experiencing financial hardship or affordability challenges that make it difficult to cover relocation expenses on your own?
☐ Yes
☐ No
Explain:

2. Do you have difficulty staying with family members during the relocation process?
☐ Yes
☐ No
Explain:

3. Are medical conditions or disabilities affecting your ability to relocate?
☐ Yes
☐ No

4. Do you require accessible housing due to a disability or medical condition?
☐ Yes
☐ No

5. Do you have employment-related concerns that could be affected by relocation?
☐ Yes
☐ No

6. Will relocation affect your child's or children's schooling?
☐ Yes
☐ No

7. Do you provide care for an elderly or disabled family member whose care may be affected by relocation?

☐ Yes

☐ No

8. Please describe any additional hardships or special circumstances the relocation program should consider.

I certify that the information provided is true, accurate, and complete to the best of my knowledge.

Homeowner Signature: _____

Date: _____

Relocation Coordinator Use:

Hardship Verified:

☐ Yes

☐ No

Is Homeowner able to relocate if owner-occupied or able to relocate tenant(s):

☐ Yes

☐ No

Additional Assistance Recommended:

Comments:

Relocation Assistance Approved:

☐ Yes

☐ No

CITY OF MILWAUKEE
HEALTH DEPARTMENT

CDBG Milwaukee

Consent and Authorization for the City of Milwaukee Lead Hazard Reduction Program to Disclose and Use Confidential Information (H-3014 C)

Date: _____

To:
Lead Hazard Reduction Program
841 North Broadway, Rm. 118

Milwaukee, WI 53202

Re:
Client's Name: _____
Client's Address: _____ Unit #: _____

City: _____ State: _____ ZIP: _____

I/We the undersigned client, or in the case of a minor, the parent or guardian, hereby voluntarily consent and grant permission to:

a. The above-named person or entity to **fully disclose, discuss,** and **release** to a representative of the City of Milwaukee Lead Poisoning Prevention Program any and all private, confidential and other information and provide all documents necessary to be useful in completing my/our application for service through the City of Milwaukee Lead Hazard Reduction Program.

b. The City of Milwaukee Lead Hazard Reduction Program to **fully disclose, discuss,** and **release** to the above-named person or entity any and all information and documents necessary to be useful to complete all applications for providing said services.

I/We understand that the City of Milwaukee Lead Hazard Reduction Program will treat this information in a confidential manner, and I/we voluntarily consent and grant permission to the City of Milwaukee Lead Hazard Reduction Program and its representatives to use and fully disclose, discuss, and release all such information to doctors, therapists, other professionals, and persons who have a need to know such information in order to complete my/our application, evaluation, or for the providing of said services by the City of Milwaukee Lead Hazard Reduction Program.

Unless revoked in writing and delivered to the City of Milwaukee Lead Hazard Reduction Program, this Consent and Authorization will expire on the date that the client is no longer involved or enrolled in the program. No revocation shall affect any action that been taken in reliance upon this Consent and Authorization. The recipient can rely on the presentation of this Authorization as proof that it has not expired or been revoked.

I/We understand that in order to enroll or receive services through the program, I/we must sign this Consent and Authorization.

I/We certify that prior to signing this consent and Authorization, I/we read it and understand all items and terms herein, and that this Consent and Authorization is signed and given freely, voluntarily, and knowingly. A copy or facsimile of this Consent and Authorization shall be as valid as the original. I/We have received a copy of this form.

Client, Parent, or Guardian's Signature: _____ Date: _____

Client, Parent, or Guardian's Signature: _____ Date: _____

Home Environmental Health
841 North Broadway, 1st Floor | Milwaukee, WI 53202
(414) 286-2165
milwaukee.gov/HEH

LIVING YOUR BEST LIFE.

CITY OF MILWAUKEE
HEALTH DEPARTMENT

CDBG Milwaukee

Employment Verification Sheet (H-3014 D)

Date: _____

To:
Company Name: _____
Address _____ Unit #_____

City: _____ State____ ZIP_____

Re:
Employee: _____
Address: _____ Unit # _____

City: _____ State:____ ZIP: _____

Dear Employer:

The employee listed above has applied for services through the City of Milwaukee Home Environmental Health Division. Please complete the form below.

Thank you for your assistance and your prompt attention to this matter.

If you have any questions please contact the Lead Enrollment Team at **414-286-2165** Monday - Friday between 8am and 4:30pm.

SECTION 1: EMPLOYMENT STATUS

Is the employee listed above currently employed by your company? ☐Yes ☐No If "yes," complete Section 2.

If "no," employment end date: _____

Reason employment ended: ☐Never employed ☐Laid off ☐Quit ☐Strike ☐Fired ☐Other: _____

Date of final paycheck: _____ Gross pay for final month: $_____

SECTION 2: EMPLOYMENT INFORMATION

Start date of employment: _____ Date first paycheck received: _____

Employment type: ☐ Temporary ☐ Permanent Title: ☐ Manager Other: _____

Please provide an estimate of the following wage information for the next 30 days:

Type of Pay	Best Estimate of Weekly Hours	Rate of Pay per Hour	Regular Scheduled Weekly Hours
Regular:	_____	$_____	_____
Overtime:	_____	$_____	

Salary if not paid hourly: $ _____

Frequency of pay: ☐Weekly ☐Bi-weekly ☐Semi-Monthly ☐Monthly ☐Irregular

EMPLOYER

Supervisor signature:_____ Print Name: _____ Date: _____ Phone: _____

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