Lead and Healthy Homes Section
P.O. Box 30195
Lansing, Michigan 48909
(517) 335-9390

HEALTHY HOMES UNIVERSITY PROGRAM APPLICATION

Part I. Please fill out the information below:

Renter	Homeowner
Name: ____________________	Name: ____________________
Address: ____________________ Apt. _____	Address: ____________________ Apt. _____
City: __________ State: __________ Zip: _____	City: __________ State: __________ Zip: _____
County: ____________________	County: ____________________
Home Phone: __________ Cell Phone: __________	Home Phone: __________ Cell Phone: __________

Part II. Please fill out the following information for each child under the age of 18 years who lives in the house:

For Staff Use Only

Child 1

				For Staff Use Only
Name of child: ____________________ Your relationship to child: ____________________				
Date of birth: __________ Sex (M/F): _____ Race (Optional): ____________________				
Name and phone number of the legal guardian/parent of this child: ____________________				
Have you ever been told by a doctor or nurse that this child has asthma?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	Yes	No	Don't Know	
Has this child ever had episodes of wheezing (whistling in the chest) in the past 12 months?	Yes	No	Don't Know	
In the past 12 months, have you heard this child wheeze or cough during or after active play?	Yes	No	Don't Know	
Other than a cold, in the past 12 months, has this child had a dry cough at night?	Yes	No	Don't Know	
In the past 12 months, has this child been to a doctor, urgent-care, emergency room, or a hospital for wheezing?	Yes	No	Don't Know	
In the past 12 months, has this child had a problem with sneezing, or a runny, or blocked, or stuffy nose when he/she **did not** have a cold or the flu?	Yes	No	Don't Know	
In the past 12 months, has this nose problem been accompanied by itchy-watery eyes?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had hay fever?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had eczema?	Yes	No	Don't Know	
Has this child ever had an itchy rash which was coming and going for at least 6 months?	Yes	No	Don't Know	

For additional children, please complete reverse side of this sheet.

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Child 2

Name of child: ________________________ Your relationship to child: ____________				
Date of birth: ____________ Sex (M/F): _____ Race (Optional): ____________________				
Name and phone number of the legal guardian/parent of this child: ________________________				
Have you ever been told by a doctor or nurse that this child has asthma?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	Yes	No	Don't Know	
Has this child ever had episodes of wheezing (whistling in the chest) in the past 12 months?	Yes	No	Don't Know	
In the past 12 months, have you heard this child wheeze or cough during or after active play?	Yes	No	Don't Know	
Other than a cold, in the past 12 months, has this child had a dry cough at night?	Yes	No	Don't Know	
In the past 12 months, has this child been to a doctor, urgent-care, emergency room, or a hospital for wheezing?	Yes	No	Don't Know	
In the past 12 months, has this child had a problem with sneezing, or a runny, or blocked, or stuffy nose when he/she **did not** have a cold or the flu?	Yes	No	Don't Know	
In the past 12 months, has this nose problem been accompanied by itchy-watery eyes?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had hay fever?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had eczema?	Yes	No	Don't Know	
Has this child ever had an itchy rash which was coming and going for at least 6 months?	Yes	No	Don't Know	

Child 3

Name of child: ________________________ Your relationship to child: ____________				
Date of birth: ____________ Sex (M/F): _____ Race (Optional): ____________________				
Name and phone number of the legal guardian/parent of this child: ________________________				
Have you ever been told by a doctor or nurse that this child has asthma?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	Yes	No	Don't Know	
Has this child ever had episodes of wheezing (whistling in the chest) in the past 12 months?	Yes	No	Don't Know	
In the past 12 months, have you heard this child wheeze or cough during or after active play?	Yes	No	Don't Know	
Other than a cold, in the past 12 months, has this child had a dry cough at night?	Yes	No	Don't Know	
In the past 12 months, has this child been to a doctor, urgent-care, emergency room, or a hospital for wheezing?	Yes	No	Don't Know	
In the past 12 months, has this child had a problem with sneezing, or a runny, or blocked, or stuffy nose when he/she **did not** have a cold or the flu?	Yes	No	Don't Know	
In the past 12 months, has this nose problem been accompanied by itchy-watery eyes?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had hay fever?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had eczema?	Yes	No	Don't Know	
Has this child ever had an itchy rash which was coming and going for at least 6 months?	Yes	No	Don't Know	

Part III. Please answer the following questions by checking **Yes, No**, or **Don't Know**	Yes	No	Don't Know	***Staff Use Only***
1. Does any occupant in the home have a disability? Explain: __________________________				
2. Is this a single parent/guardian household?				
3. Do you plan to move within the next 6 months?				
4. What is the ZIP Code of this home?	ZIP:			
5. Does anyone smoke in the home?				
6. Are there any other sources of smoke in the home? If yes, please circle: Gas Stove Wood Burning Stove Kerosene Heaters Fireplace Other _______________________				
7. Does the home have any pets such as dogs, cats, hamsters, birds, or other feathered or fury pets that spend time indoors?				
8. In the past 30 days, has anyone seen cockroaches in the home?				
9. In the past 30 days, has anyone seen evidence of mice, rats or other rodents in the home?				
10. In the past 30 days, has anyone seen or smelled mold or a musty odor inside the home? (Do not include mold on food.)				
11. Has a child in this home been injured and taken to the doctor or emergency? If yes, please circle type: Slip/Fall Burn Electric Shock Poisoning Chemical Burns Cut Other ______________________________				
12. How did you hear about this program? Friend/Relative Hospital Doctor/Nurse Community Activity Government Agency Media Other _______________________				
13. What is the language(s) spoken in the home?				

Part IV. Please complete and attach copies.

1. What is the total yearly income of the household? Attach copies of last year's W2s or current pay stubs **and** proof of other income (i.e., disability, alimony, federal assistance, child support, etc.)	$	

Questions? Please call Linda Stewart, Assistant Project Coordinator at (517) 335-8867 or toll-free at (866) 691-5323.

All medical information obtained for this program will be kept confidential in accordance with applicable State and Federal laws and guidelines. The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

I verify that the answers provided above are true.

_________________________________ _________________________________ ___________

Name (Please print) Signature Date

Mail completed application to: **Lead & Healthy Homes Section**
P.O. Box 30195
Lansing, MI 48909

FOR STAFF USE ONLY

DATE APPLICATION RECEIVED: _______________ INITIALS: _____ INSPECTION/ASSESSMENT: ☐ Yes ☐ No INITIALS_________

DATE APPLICATION ENTERED INTO DATABASE: ______ INITIALS: ____ BASIC INTERVENTION: ☐ Yes ☐ No INITIALS:_________

DATE APPLICANT CONTACTED: _______________ INITIALS: _____ CUSTOM INTERVENTION: ☐ Yes ☐ No INITIALS:_________

APPROVED PENDING VERIFICATION OF THE FOLLOWING: ☐ INCOME ☐ INCOMPLETE OR MISSING INFORMATION