SUMMIT COUNTY PUBLIC HEALTH (SCPH)
HUD LEAD-BASED PAINT HAZARD REDUCTION
GRANT PROGRAM

HOMEOWNER APPLICATION

Review of Program Eligibility & How the Program Works

ILENE SHAPIRO
COUNTY EXECUTIVE

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 on a regular basis.
- The home meets local ordinances and housing codes.
- Property taxes are not delinquent.
- Household income is within 2023 HUD Income Guidelines (subject to change).

REHAB PROGRAM/PURCHASE, REHAB, RESALE/ LEAD/ HSTS(CDBG) Economic Development								
% AMI	1 Person	2 Person	3 Person	4 Person	5 Person	6 Person	7 Person	8 Person
30% AMI	$18,250.00	$20,850.00	$24,860.00	$30,000.00	$35,140.00	$40,280.00	$45,420.00	$50,560.00
50% AMI	$30,400.00	$34,750.00	$39,100.00	$43,400.00	$46,900.00	$50,350.00	$53,850.00	$57,300.00
80% AMI	$48,650.00	$55,600.00	$62,550.00	$69,450.00	$75,050.00	$80,600.00	$86,150.00	$91,700.00

Revised 5.15.2023

How the Program Works After the Application is Approved *timeline may vary for each applicant

- A SCPH Lead Risk Assessor will contact you to schedule a time to do a lead risk assessment. A report will be mailed with a list of the lead hazards.

- The Owner(s) will sign off on the scope of work to be bid on by contractor(s) and will receive an estimated cost of work.

- A pre-bid meeting is scheduled at the house to allow contractors to see the work that needs to be done.

- The Contractor with the lowest most responsive bid is awarded the job and the County of Summit will hold the contract with the winning contractor.

- The County of Summit will schedule a time for the owner(s) to sign their mortgage documents and access agreement. The mortgage amount is calculated by taking 50% of the contractors lead bid and securing it with a 5 year, deferred, forgivable loan and the remaining bid is a grant to the owner. The loan is forgiven in equal portions over 5 years on the anniversary date of executing the mortgage documents. The amount forgiven each year is not pro-rated during the year. The loan will become due if the home is sold, transferred or no longer the primary residence of the owner within the loan term.

- The owner must add the County of Summit as an “Additional Insured” to their homeowners’ insurance policy for the term of the loan. Documentation must be provided prior to closing of the addition.

- Property taxes must be current and remain current for the term of the loan.

- Relocation is required while the lead work is being completed at the home, and it is encouraged that the owner stays with friends and/or family. If this is not possible, a hardship letter must be provided at the time of the loan closing. SCPH will select and pay for a hotel for relocation. The owner MUST provide a debit/credit card at check in for any incidentals. Only the individuals listed on the application as living in the home are eligible for relocation. Failure to follow hotel policies may result in a loss of your reservation. SCPH will not make additional arrangements and the owner is not permitted to return to the home until the lead work is completed and a clearance inspection has been conducted. SCPH must be made aware of any animals that will be going to the hotel prior to reservations being made. Boarding of animals is not covered by the program. Animals may NOT be left either inside or outside at the home. If any animals are

left, Animal Control will be contacted to remove the animals and the owner will be responsible for any fees to get the animal(s) back.

- SCPH Grant staff will call to give the date that the contractor will begin lead work. A time will be scheduled to plan for relocation to a friend or family home or to a hotel with a kitchenette, of SCPH choosing, paid by the Program. No food will be purchased using the program. Only individuals listed on the application as living in the home will be permitted to use the hotel pool, additional guests are not permitted to use hotel amenities.

- Lead work will not start if the dwelling is cluttered, infested with insects or rodents, or unsanitary. The program will NOT pay for pest extermination. Pest extermination must be completed by a licensed pest control operator and a receipt shall be shown to Summit County Public Health.

- The Owner(s) will clear areas where work is being done and take down window covers.

- Once lead work begins, no one can enter the residence until it is tested and found lead safe. SCPH staff will call the owner and advise when they are able to return.

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 or 330-643-8013 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

SUMMIT COUNTY PUBLIC HEALTH (SCPH)
HUD LEAD-BASED PAINT HAZARD REDUCTION GRANT PROGRAM

Review of Program Eligibility & How the Program Works

ILENE SHAPIRO
COUNTY EXECUTIVE

PLEASE MAIL, EMAIL, OR BRING THE APPLICATION AND COPIES OF THE REQUIRED DOCUMENTS TO THE FOLLOWING ADDRESS:

County of Summit
Department of Community and Economic Development
175 S. Main St., Suite 207
Akron, OH 44308
Website: https://co.summitoh.net
Email: hmiller@summitoh.net

HOMEOWNER REQUIRED DOCUMENTS:

- ☐ **Proof of Identity** (current photo ID, birth certificate and social security card)
- ☐ **Federal Tax Return** – a copy of the 2023 tax return with all Schedules which must be signed and dated for all adults 18 years and older.
- ☐ **W-2** Statement of Earnings for 2023 for all adults 18 years and older
- ☐ **Social Security Benefits Statement** (Form SSA–1099) for 2023
- ☐ Notarized letter for every adult, 18 years or older, in the home, who does not file a Federal Tax return with the reason – unemployed, senior citizen, full-time student, or other
- ☐ **Last 6 pay stubs** for all adults 18 years and older who are employed
- ☐ **Social Security Award Letter** for 2023 and 2024
- ☐ **Determination of Unemployment Compensation Benefits** document with date first paid out
- ☐ Notarized letter signed and dated for every person living in the home over age 18 years with no income
- ☐ **Birth certificates** for all children under 6 living in the home or visiting the home
- ☐ Notarized letter signed and dated by the parent or guardian of the visiting child under the age of 6. Write the child's name, birthdate, and the ***number of days a week*** and ***hours a day*** that the child stays in the home
- ☐ Court documents for adoption/legal custody/foster care
- ☐ **Pension document** with the 2023 yearly amount
- ☐ Divorce documents/decree/separation agreement
- ☐ **Last 3 bank account statements** for all adult occupants - checking, savings, and credit union
  ***Please write source of income for all unidentified bank deposits. ***

The above information will be required for all adults living in the home. Please provide only the documents that are applicable to you. Additional documents may be requested as your application is reviewed. If you cannot make copies of documents, we can make copies for you.

EQUAL HOUSING LENDER

SUMMIT COUNTY PUBLIC HEALTH (SCPH)
HUD LEAD-BASED PAINT HAZARD
REDUCTION
GRANT PROGRAM

ILENE SHAPIRO
COUNTY EXECUTIVE

HOMEOWNER APPLICATION

PART 1: APPLICANT INFORMATION

NAME (First) Middle) (Last)

ADDRESS (City) (Zip Code)

Social Security Number: _____ Date of Birth: _____

Daytime Phone: _____ Evening Phone: _____

Email: _____ Cell Phone: _____

Is English your first language? ☐ Yes ☐ No My first language is: _____
Please check one of the following: (Required for Federal Funding Purposes)

■ Female ☐ Male Are you a Veteran? ☐ Yes ☐ No Are you Hispanic/Latino? ☐ Yes ☐ No

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Please check one of the following: (Required for Federal Funding Purposes)

☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Other Multi Racial

☐ Native Hawaiian/Other Pacific Islander ☐ Asian/White ☐ American/Indian/Alaskan Native/White

☐ American Indian/Alaskan Native/Black/African American ☐ Black/African American/White

List your employer/s and income:

☐ Check here if you are unemployed.

	Employer/Employers	Amount of Paycheck (**Monthly Gross**, Before Taxes)
Current		
2023		

List OTHER sources of income:

	Yes	No	Total Amount Per Month	
			Current	**2023**
Child Support	☐	☐		
Alimony	☐	☐		
Pension	☐	☐		
Social Security or SSI	☐	☐		
Disability Benefits	☐	☐		
Unemployment Benefits	☐	☐		
Do you have other income?	☐	☐	**If yes, please write and attach page listing the income.**	

PART 2: CO-APPLICANT INFORMATION

☐ Check here if there is **no** co-applicant and go to Part 3 of the application.

TENANT CO-APPLICANT NAME (First) Middle) (Last)

RENTAL ADDRESS (City) (Zip Code)

Social Security Number: _____ Date of Birth: _____

Daytime Phone: _____ Evening Phone: _____

Email: _____ Cell Phone: _____

Is English your first language? ☐ Yes ☐ No My first language is: _____
Please check one of the following: (Required for Federal Funding Purposes)

☐ Female ☐ Male Are you a Veteran? ☐ Yes ☐ No Are you Hispanic/Latino? ☐ Yes ☐ No

☐ Single ☐ Married ☐ Divorced ☐ Widowed
Please check one of the following: (Required for Federal Funding Purposes)

☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Other Multi Racial

☐ Native Hawaiian/Other Pacific Islander ☐ Asian/White ☐ American/Indian/Alaskan Native/White

☐ American Indian/Alaskan Native/Black/African American ☐ Black/African American/White

List your employer/s and income:
☐ Check here if you are unemployed.

	Employer/Employers	Amount of Paycheck (**Monthly Gross**, Before Taxes)
Current		
2023		

List OTHER sources of income:

	Yes	No	Total Amount Per Month	
			Current	**2023**
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 with the Application.**	

PART 3: OTHER OCCUPANTS

Write in the names of OTHER people currently living in the home.

Do not write the Applicant or Co-Applicant names here.

Name	Relationship to Applicant	Date of Birth	Social Security Number (last 4 numbers)

Do you care for children younger than 6 years of age in your home?

☐ Yes ☐ No

If yes, fill in the next section.

Name of Child	Birthdate	Days per Week	Hours Per Day

Referral Program: Has anyone in the home received an Asthma diagnosis from the Doctor? If yes:

Name: _____ Age: _____

PART 4: ASSETS

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

☐ Check here if no bank accounts.

Name of Bank or Credit Union	Checking or Savings Account	Balance

List all Stocks, Bonds, Certificate of Deposits, Securities, IRAs, or Other.
(Withdrawals from accounts are counted as household income.)

☐ Check here if no stocks, bonds, CDs, etc.

Name of Stock, Money Market Account, Government Bond, Or Other	Approximate Value

List Other Real Estate Owned or Co-Owned:
Rent received is counted as household income.

☐ Check here if no other real estate.

Rental Property, Vacation Home, Or Other	Address	Rent Received

PART 5: MORTGAGE INFORMATION

Is your home paid in full? ☐ Yes ☐ No

List all the mortgages on the property:

Bank/Lending Institution	Original Mortgage Amount	Current Mortgage Balance	Monthly Payment

CIRCLE the type of mortgage loan - FHA VA Conventional Land Contract

Does the mortgage payment include property taxes and insurance? ☐ Yes ☐ No ☐ Not Applicable

Do you currently have homeowner insurance? ☐ Yes ☐ No
Copy of declarations page must be provided with application.

Insurance Company Name: _____

Agent Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

PART 6: PERMISSION TO RELEASE OR VERIFY APPLICANT INFORMATION

Inquiries may be made about items listed below for the applicant, co-applicant, and other occupants of the household age 18 and over. Failure to verify information may result in a delay or may result in your application not being approved.

APPLICANT INFORMATION COVERED

I/we authorize and release the County of Summit and/or HUD to obtain information that is pertinent to my/our eligibility for the Summit County Public Health Lead-Based Paint Hazard Control Grant Program and to verify the information that I/we have provided.

Alimony or Separation Payments	Full-Time Student Status	Social Security Benefits
Assets (all sources)	Handicap Assistance Expense	Tax Returns
Assets on Deposit	Income (all sources)	Unemployment Benefits
Bank Accounts	Income from Business	VA Benefits
Child Care Expenses	Liens	Other:
Child Support Payments	Medical Expenses	
Employment	Pension and Annuities	

I/we acknowledge and understand:

Mortgage documents for work to be done will be signed at the County of Summit Department of Community and Economic Development office located at 175 S. Main St., Room 207, Akron, Ohio 44308.

A photocopy of this application is valid as the original. Notarized documents must be original.

The Summit County Public Health representative has my/our permission to complete or fill in missing information on my/our application.

Signature of Applicant Date

Signature of Co-Applicant Date

Signature of Other Adult Date

Signature of Other Adult Date

PART 7: HOMEOWNER AGREEMENT

The Owner(s) understands that it is 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 (Section 1001 of Title 18 of US Code).

The Owner(s) understands that approval of the application is not guaranteed. The application may not be approved due to income eligibility, the condition of the house, or the cost of the amount of work needed.

The Owner(s) understands that a lead risk assessment must be completed on the home by Summit County Public Health if the application is approved. Access to each room, from attic to basement, and a clear path to each window are needed to test the paint. Animals must be kept outside during the lead risk assessment. If the Lead Risk Assessor does not have access to each room and window, or pets are not contained, the lead risk assessment will be canceled and rescheduled. A lead risk assessment report will be mailed. It will list lead hazards and what lead work may be provided.

The Owner(s) understands that all occupants and pets must move out while lead work is being done; and will make plans to move in with a friend or family member. A hotel suite with a kitchenette will be reserved and paid for by the Program. The Owner(s) will need to provide a credit card to pay for miscellaneous charges, when checking in.

The Owner(s) understands that, before moving out, furniture needs to be moved in work areas; window treatments need to be removed where windows are being replaced; access to windows must be clear; porches must be clear; and valuables must be secured. The property must be pest and rodent free. The Applicant(s) understand(s) that LBPHCP is not responsible for anything broken or stolen before, during, or after the work is done.

The Owner(s) understands that any verbal or physical abuse or threats to Summit County staff, contractors, or their employees may result in the immediate termination of LBPHCP assistance and that any work performed will be at the expense of the Applicant(s).

The Owner(s) understands that a photocopy of this application is valid as the original. All notarized documents must be provided as originals.

The Owner(s) confirms that a copy of the Notice of Privacy Practices has been received.

Signature of Applicant	Date	Signature of Co-Applicant	Date

PART 8: WALK AWAY POLICY

Regardless of eligibility, under certain circumstances, an applicant may not receive assistance through the Lead Based Paint Hazard Reduction Program. Such circumstances include, but are not limited to:

- The homeowner and/or applicant becomes verbally or physically abusive and/or threatens staff members
- During the course of the lead abatement work the owner and/or tenant continually fails to cooperate with staff or contractors
- 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
- Failure on the part of the applicant/owner to demonstrate pride of ownership. Conditions included under pride of ownership include, but not limited to:
- Abuse of animals: evidence of unsanitary conditions
- Illegal or improper use of the property
- Housekeeping and maintenance: extreme conditions of clutter or filth in or around the house

Under any of the circumstance's assistance may be withheld and/or terminated at the discretion of the program administrator.

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

_____ _____
Applicant Signature Date

_____ _____
Co-Applicant Signature Date

Summit County Public Health
1867 W. Market St. • Akron, OH 44313 • 330-923-4891

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how your 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.

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.

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.*

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 must 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 about you:
	  • 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. For example, drug and alcohol treatment records are subject to the following restrictions:

- Information regarding participation in a treatment program or identifying a patient as a substance abuser will not be disclosed except as permitted by applicable law.
- Disclosures, other than those explicitly required by 42 CFR Part 2, require consent in writing from the patient unless the patient is incompetent, the patient condition prevents knowing or effective action, or the patient is deceased. We may not release the records of minors without the consent of the minor, except as required by law.
- Disclosures by court order require both a court order and a subpoena.
- Disclosures may be made for scientific research, program evaluations or audits, and emergencies.

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: 5/15/2017

For questions, please contact the Summit County Public Health Privacy Official by calling 330-923-4891.

PART 10: MULTI-PARTY AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Summit County Combined General Health District ("Health District") to

☐ **Release or** ☐ **Obtain Information From: (check one or both) from the records indicated below:**

Obtain information from:	
Agency:	**Agency:**
Phone Number:	**Phone Number:**
Release Information To:	
County Agencies:	
Summit County Department of Community and Economic Development	
Purpose: Determination of Eligibility	
Other Agency/Person:	
Agency:	
Purpose:	
Other Agency/Person:	
Agency:	
Purpose:	
Other Agency/Person:	
Agency:	
Purpose:	
Other Agency/Person:	
Agency:	
Purpose:	

Type of Information to be Shared:

You may share all or any part of my record with the agencies or persons listed above, as provided by law.

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 may include treatment for mental illness (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 Patient or Patient's Representative: _____

Patient's Representative (print): _____

Authority of Representative: _____

Date: _____

Expiration date or event: _____

(If blank, your consent will automatically expire when your client relationship terminates)

If choosing to REVOKE, complete the following section:

Written Revocation: I wish to cancel this Release effective:

_____ **Date**

_____ _____

Parent/Guardian or Person Authorized to revoke consent **Date**

_____ _____

Witness **Date**

PART 11: INTERNET

INTERNET PROVIDER INFORMATION RELEASE AUTHORIZATION*

Please fill out the release that applies to your household.

Internet Provider Release:

I hereby authorize_____ (***internet provide name***) to release information on my internet bills, past and present and future to the County of Summit Home Weatherization Assistance Program or its designees. I understand that this information will be used only to provide data to the above-named agency and its designees.

How much do you pay for Internet (monthly rate): $_____

Do you receive assistance from the *Affordable Connectivity Program* (ACP) for your internet services? ☐ yes ☐ no, if no, would you like more information ☐ yes ☐ no

What do you use your internet for:

- ☐ Streaming TV
- ☐ School or work
- ☐ Gaming
- ☐ Other_____

UNITE US

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 that 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.

Client

Name: _____

Signature: _____

Date: _____

Personal Representative or Guardian (only if applicable)

Name: _____

Signature: _____

Date: _____

Relationship to Client: _____

Preferences (You may select more than one):

Email: _____ Text: _____ Phone: _____