ILENE SHAPIRO
COUNTY EXECUTIVE

COUNTY OF SUMMIT
LEAD HAZARD REDUCTION
OWNER OCCUPIED APPLICATION

ABOUT THE PROGRAM

The County of Summit HUD Lead-Based Paint Hazard Reduction Program is not an emergency program. Homes must be owner-occupied and in the County of Summit, Ohio.

Rental owners and their tenants 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.
- The home is free of clutter, insects, rodents, and unsanitary conditions.

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 (SCPH) 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

ILENE SHAPIRO
COUNTY EXECUTIVE

COUNTY OF SUMMIT
LEAD HAZARD REDUCTION
OCCUPIED RENTAL 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
- ☐ 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 any 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 current homeowners' insurance with the current effective dates

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.

INCOME LIMITS* - Community and Economic Development								
% AMI	1 Person	2 People	3 People	4 People	5 People	6 People	7 People	8 People
80%	$56,200	$64,200	$72,250	$80,250	$86,700	$93,100	$99,550	$105,950

*Income Limits Subject to Change *Revised effective 4/1/2025

EQUAL HOUSING LENDER

ILENE SHAPIRO
COUNTY EXECUTIVE

Mail documents to: **County of Summit**
SCLHR
175 S Main St, Room 207
Akron, Ohio 44308

COUNTY OF SUMMIT
LEAD HAZARD REDUCTION
OWNER OCCUPIED APPLICATION

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

PART 1 – APPLICANT INFORMATION

Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone #: _____ Cell Phone #: _____

Social Security Number: _____ Date of Birth: _____

Email: _____

Gender Identity: ☐ Male ☐ Female ☐ Prefer not to say
Are you a veteran? ☐ Yes ☐ No
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

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

☐ White
☐ Black/African American
☐ American Indian/Alaskan Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ Black/African American/White
☐ Asian/White
☐ American Indian/Alaskan Native/White
☐ Am. Indian/Alaskan Native/Black/African Am.
☐ Other Multi-Racial

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 2 – CO-APPLICANT INFORMATION ☐ **Check here if there is no Co-Applicant**

Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone #: _____ Cell Phone #: _____

Social Security Number: _____ Date of Birth: _____

Email: _____

Gender Identity: ☐ Female ☐ Male ☐ Prefer not to say

Are you a veteran? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

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

☐ White
☐ Black/African American
☐ American Indian/Alaskan Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ Black/African American/White
☐ Asian/White
☐ American Indian/Alaskan Native/White
☐ Am. Indian/Alaskan Native/Black/African Am.
☐ Other Multi-Racial

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 3 – EMERGENCY CONTACT (AT LEAST ONE MUST BE PROVIDED)

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

PART 4 – HOUSEHOLD COMPOSITION

Please read the instructions carefully. Enter the information completely. Including yourself, list the names, dates of birth, relationships, and Social Security Number(s) of everyone living in your home. **Attach proof of income for any residents over 18**. 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. All household members must be listed. Use an additional sheet if necessary.

Name	**Date of Birth**	**Relationship**	**Social Security Number**

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

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

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
		$
		$
		$

Stocks, Bonds, Certificates of Deposit, Securities, IRA's, Etc.

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
	$
	$
	$

This section is intentionally left blank.

PART 6 – CONDITIONS

The Applicant(s) agree that the presence of hazardous conditions may disqualify and exclude their housing unit from eligibility for participation in the HUD Lead-Based Paint Hazard Reduction 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 HUD Lead-Based Paint Hazard Reduction 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 HUD Lead-Based Paint Hazard Reduction 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 is intentionally left blank.

PART 7 – 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 County of Summit Department of Community and Economic Development (SCDOD) review panel 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 SCDOD review panel will all 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 SCDOD 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

PART 8 – 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 and/or applicant 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
    - 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 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

This section is intentionally left blank.

PART 9 – 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: _____

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 SUMMIT

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)

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 lives in the home or visits on a regular basis 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

Obtain Information from:	
Agency:	**Purpose:**
Summit County Department of Community Development	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 Applicant Date

_____ _____
Signature of Parent/Guardian of Child(ren) 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.*

continued on next page

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 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.

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:

continued on next page

(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.