Hennepin County Healthy Homes Grant Occupant

CONSENT TO PARTICIPATE IN THE HENNEPIN COUNTY HEALTHY HOMES GRANT PROGRAM OF THE U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD) AND HENNEPIN COUNTY

1. DESCRIPTION OF THE PROJECT

I request to be enrolled in Healthy Homes Production Grant (HHP) with Hennepin County Housing, Community Works, & Transit Department (HCWT). My participation in the project is voluntary I am free to withdraw at any time prior to work starting. I understand that enrollment in HHP will assist with identifying and fixing healthy homes hazards found in my home.

I will allow HCWT or its agents access to the property to conduct a Healthy Homes inspection to determine if hazards are present and again after any work is completed for a final inspection. I agree to submit verification of household income to HCWT for all occupants of my dwelling unit. I agree to maintain my dwelling unit to reduce hazards.

All occupants must be protected from lead-based paint hazard reduction activities. I agree to abide by the occupant protection plan developed specifically to protect me during the work. I understand that this plan may require that I temporarily relocate from my dwelling unit.

2. BLOOD LEAD TESTING

All children residing in the dwelling unit under the age of six years will have their blood tested for lead prior to the start of the project. I understand that I am responsible for obtaining blood lead testing and any needed follow-up care for child(ren) under my care. I am responsible for the cost of any medical care indicated due to elevated blood lead levels.

3. HOLD HARMLESS CLAUSE

My participation in the HHP is voluntary and for my benefit. As a condition of my participation, I (we) agree to hold Hennepin County and the U.S. Department of Housing and Urban development (HUD) harmless and agree not to commence any legal action, sue or make any claim against Hennepin County and HUD for any normal activities of the grant program. I understand that hazards may be identified that cannot be fixed by the grant program. I will be given information on how to minimize my family's exposure to them and I understand it will be my responsibility to follow the recommendations.

4. BENEFITS TO ME

My participation in this program will provide me with a safer dwelling unit. If the scope of work includes lead-based paint hazard reduction, I may also be reimbursed for documented relocation expenses including hotel, local travel, and food up to $150 per day with the total amount not to exceed $750. Any other relocation expenses must be approved in advance and Hennepin County reserves the right to deny claims deemed ineligible or not cost reasonable.

By these initials I acknowledge that I have been informed of the relocation requirements:_____

5. PROGRAM CONTACTS

If I have questions about this program or this form, I may contact Melisa Illies at 612-348-2020 (melisa.illies@co.hennepin.mn.us) or Mike Jensen at 612-348-2114 (michael.a.jensen@co.hennepin.mn.us).

Hennepin County Housing, 701 4th Ave S, Suite 400, Minneapolis MN 55415
Fax: (612) 348-2920
rev: 4/24/2012

6. OCCUPANT / ELIGIBILITY INFORMATION

OCCUPANT CONTACT INFORMATION:

Address of Property: _____Unit_____

Name _____Phone #_____or_____

Total number of occupants: _____ Number of children under age 6: _____

List **all** occupants of this dwelling (Blood Lead Levels for children under 6 only):

NAME (all occupants)	Date Of Birth	Relationship	Blood Lead Level (<6 only)	Test Date

Are your children on Medicaid Assistance (Circle One) Yes No

Ethnic Group (Circle one) Hispanic or Latino Non Hispanic or Latino

Race:_____ Single Head of Household? _____

In order to qualify for enrollment, one of the following income verifications is included for all income earners in the household: Most recent Tax Return with W2 **or** Check stub with "Year to Date" income or three consecutive check stubs **or** statement of benefits (e.g. MFIP, SSI).

9. CONSENT / RELEASE

I, _____, consent to participate in the HHP as conducted by HCWT and hereby authorize my medical provider or other agencies to release copies of blood lead test result records pertinent to my child(ren) to HCWT with the understanding that this and the other above information will be kept confidential and used only for enrollment eligibility purposes.

_____ Date: _____
Occupant

_____ Date: _____
Interpreter/Translator

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