LEAD PROTECTION PROGRAM

Is your home a safety hazard for your child?

Indiana Lead Protection Program offers qualified residents FREE services to help

If you live in an older home with peeling paint or old windows, you might be eligible for free lead-remediation help and repairs, including:

- **FREE** lead assessment of your home
- **FREE** lead-safety work, which could include new windows, doors, painting or special cleaning

There is NO COST, whether you own or rent your home.

- Landlords will be asked to sign an affordability agreement.
- Tenants will need their landlords' permission before beginning work.

To qualify, you must meet ALL of the requirements in EITHER Option 1 or Option 2.

OPTION 1

- ☑ A child under 6 years old OR a pregnant female LIVES IN or FREQUENTLY VISITS your home.
- ☑ Your home is located in EAST CHICAGO or SOUTH BEND, Indiana.
- ☑ Property taxes on your home are paid and up-to-date.
- ☑ You have homeowners' or renters' insurance.
- ☑ Your home (or rented house containing only one or two units) was built prior to 1978.
- ☑ Someone in the home is enrolled in Medicaid or CHIP.

OPTION 2

- ☑ A child under 6 years old OR a pregnant female LIVES IN or FREQUENTLY VISITS your home.
- ☑ Your home is located in EAST CHICAGO or SOUTH BEND, Indiana.
- ☑ Property taxes on your home are paid and up-to-date.
- ☑ You have homeowners' or renters' insurance.
- ☑ Your home or apartment building was built prior to 1978.
- ☑ Your household gross income is low to moderate (by federal standards).

If you meet those requirements, it's easy to get started!

Simply fill out the attached application and return to:
Indiana Community Action Association
Attn: Justin Tyrrell
1845 W. 18th St.
Indianapolis, IN 46202

QUESTIONS? • www.in.gov/myihcda/2675.htm • toll-free (800) 382-9895 • fax (317) 634-7947

Indiana Lead Protection Program Application

If your home or apartment was built before 1978 you may qualify if:

- Either your child under the age of 6, or a pregnant woman, is enrolled in Medicaid or CHIP or;
- Your household income is considered low or moderate and has a child under the age of 6 or a pregnant woman residing in the home.

Please complete both pages and email to jtyrrell@incap.org or mail to address listed on the last page. For information please visit http:///www.in.gov/myihcda/2675.htm or call 317-638-4232.

Part 1: Applicant Information

Applicant Name: _____ Homeowner ☐ Renter ☐ Vacant ☐

Street Address: _____ P.O. Box or Apt # _____

City: _____ State: _____ Zip: _____ County: _____

Phone Numbers: (home) _____ (cell) _____

Email Address: _____

Part 2: Owner Information (If different than applicant)

Name: _____

Street Address: _____ P.O. Box or Apt # _____

City: _____ State: _____ Zip: _____

Phone Numbers: (home) _____ (cell) _____

Email Address: _____

Part 3: Property Information

Pre- 1978 Construction? Yes ☐ No ☐ Year Built (if known): _____

Total number of units in the building if multi-family _____

Total # of rooms in your unit: _____ # of bedrooms: _____ Square feet: _____

Previous Lead Inspection or Lead Risk Assessment? Yes ☐ No ☐ Don't Know ☐

Is it owned by a federal, state, or local government agency? Yes ☐ No ☐ Don't Know ☐

Is the property or occupant currently participating in a HUD Program? Yes ☐ No ☐ Don't Know ☐

Are property taxes paid up through the last billing cycle? Yes ☐ No ☐ Don't Know ☐

Does the property currently have: ☐ Water ☐ Electricity ☐ Heat

Does the property have current or previous roof leaks? Yes ☐ No ☐ Don't Know ☐

Does the property have any structural, water, or pest issues? Yes ☐ No ☐ Don't Know ☐

Please explain any other hazards: _____

How did you hear about the program? _____

INCAA INDIANA COMMUNITY ACTION ASSOCIATION

ihcda Indiana Housing & Community Development Authority

Indiana State Department of Health

Occupant Detail: Please complete the table below.

- All occupants, adults and children, must be listed and requested information provided. Attach an additional sheet of paper, if necessary.
- To qualify, a child under the age of 6, or a pregnant woman, must reside in the home.
- Homes with children under the age of 6 with a confirmed elevated blood lead level will be given the highest priority.

Name	Date of Birth (mm/dd/yy)	Age	Relation to Primary Resident	Pregnant (Yes or No)	Enrolled in Medicaid or CHIP (Yes or No)	Lead Test Results (For ages 5 and under)	Hispanic/ Latino (Yes or No)	RACE A- ASIAN B- BLACK W- WHITE H-HAWAIIAN/ PACIFIC ISLANDER I-AMERICAN INDIAN/ ALASKAN
			Primary					

By signing below, the applicant authorizes the Indiana Community Action Association (INCAA) to request lead testing information from the Indiana State Department of Health. It further authorizes the INCAA to share this information, as well as information gathered on this application, with authorized program representatives for the purposes of qualifying me for this program. By signing below, the applicant and property owner authorizes INCAA or an authorized program to contact us to request additional financial or other pertinent information as needed for program qualification. The information provided will remain confidential for satisfaction of the stated purpose only The applicant and property owner understands that completion of this application does not guarantee assistance, but only starts the process of applying for this program. We also verify that the answers provided above are accurate to the best of our knowledge. Intentionally providing false information may disqualify us from further participation in this program.

Owner/Landlord Name (please print) _____ Owner/Landlord Signature _____ Date _____

Tenant Name (if applicable, please print) _____ Tenant Signature (if applicable) _____ Date _____

If mailing this application, please send to:
Indiana Community Action Association
ATTN: Justin Tyrrell
1845 W 18th St.
Indianapolis, IN 46202

The Indiana Community Action Association does not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, political belief, status as a veteran or any other characteristic protected by the federal, state, or local law.

Program use only: App Received Date: _____ App No: _____
Medicaid/ CHIP Verified: _____ Verification Date: _____