Lead Hazard Reduction Grant Program Application

ONONDAGA COUNTY Lead Initiatives

Thank you for your interest in the Lead Hazard Reduction Grant Program. Learn more about the program below. The application follows this overview.

What is the Lead Hazard Reduction Grant Program (LHR)?

The LHR is designed to reduce lead paint hazards found in privately owned residential structures throughout Onondaga County. These hazards are often found on painted window frames, wood siding and doors, all of which can be repaired through the program. The LHR program is administered by Onondaga County Community Development and funded by the US Department of HUD.

Who can participate in the LHR Program?

Participation is on a first-come, first-served basis to applicants meeting the following requirements:

- Living in a home containing Lead Paint Hazards.
- Having a child under the age of six who lives or spends a significant amount of time in the home. **(See Residing/Child Verification Form for details)**
- Owning or occupying a one to four family residential structure built before 1978.
- Current annual gross household income of no more than 80% of the median income for Onondaga County. See chart on next page.

Eligible Properties:

- Currently protected by a current Homeowners Insurance Policy.
- Currently covered by flood insurance if located in a designated flood zone.
- Up to date on all property taxes and mortgage(s)*

  **Properties in formal repayment agreements will be considered.*

What type of work is done?

Eligible work is determined by a thorough inspection of your home. The Community Development Housing Inspector, along with an independent contractor hired by Community Development, will perform the inspection according to established standards. Common lead paint hazard reduction repairs include:

- Window and door replacement
- Exterior Siding
- Porch Work

How much assistance can I receive?

Assistance will vary depending on the scope of the hazards found in the home.

Rental units occupied by tenants that meet the program requirements are eligible to participate in the LHR Program. Vacant units may be eligible but are prioritized lower.

To be eligible, the applicant's/tenant's household gross income **must be *below*** the income limit for family size as shown in the table below. Amounts adjusted annually.

Family Size	Income Limit
1	**$58,000**
2	**$66,250**
3	**$74,550**
4	**$82,800**
5	**$89,450**
6	**$96,050**
7	**$102,700**
8	**$109,300**

Limits effective April 1, 2025

Will there be a lien placed on my property?

No, in most situations.

Owners of rental units

If the assisted unit becomes available, you must agree to give preference in renting the unit to low-income families with a child under the age of six, for a period of 3 years.

Questions?

Call the Onondaga County Community Development Division at (315) 435-3558.

The LHR Program is funded by several different Federal and State agencies. Fair Housing Laws prohibits discrimination in the sale or rental of housing based upon race, color, religion, sex, age, marital status, handicapped or familial status, or national origin.

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J. Ryan McMahon II, County Executive

LEAD HAZARD REDUCTION GRANT APPLICATION

Please see the list of required documents below. Include copies of all applicable documents listed with your filled-out application. Please note that we cannot process incomplete applications. If you have any questions, please call (315) 435-3558.

HOUSE

- ☐ Most recent monthly mortgage statement
- ☐ Homeowners Insurance Policy Declarations page

INCOME

Approval to this grant program depends on income qualification. Please see the chart below to determine if your household may qualify. Our office will require proof of current income from all applicable sources **for each household member** for the last month to verify that you income qualify.

- ☐ Employment – recent pay stubs (4 if weekly, 2 if biweekly).
- ☐ Housing Choice Voucher, if applicable
- ☐ Social Security, SSI, pension, or other retirement income – a statement which shows the gross amount received (most recent COLA letter or Proof of Income Statement). Call 1-800-772-1213 or visit socialsecurity.gov.
- ☐ Unemployment, disability, Worker's Comp – award letter or statement.
- ☐ Public Assistance – budget sheet or other official documentation.
- ☐ Alimony, child support – court decree/order or statement from Child Support Services.
- ☐ Income Tax Form – copy of most recent Federal 1040 forms, plus all 1099 forms.
- ☐ Proof of assets – bank statements, IRA/401k statements, other real estate, etc. for the current month
- ☐ Business income or rental income – receipts and/or tax return forms. Veterans Benefits – Summary of Benefits Letter. Call (800) 827-1000 or visit VA.gov
- ☐ If a household member (except minor or full-time student) has no income, please have page 6 of this document notarized before submitting.
- ☐ Full-time student over age 18 – proof of enrollment.
- ☐ Other income? Please call us at (315) 435-3558.

CHILDREN

- ☐ Results of blood lead level test from a health care provider or Onondaga County Health Department only if a child under age six resides at the property. The test results must be less than three months old. To have your child tested, call your family doctor or the Onondaga County Health Department Lead Poisoning Control Program at (315) 435-3271.

IDENTIFICATION

- ☐ Driver's license, state photo ID, passport, or birth certificate

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Please fill in all spaces or write N/A (not applicable). **Incomplete applications will be returned.**
Complete and return to Onondaga County Community Development
Remember to include copies/scans of all applicable documents listed on page 1. Questions? Call (315) 435-3558

By email: cd@ongov.net

Drop off in person: Carnegie Building, 335 Montgomery St. 2nd Floor, Syracuse, NY 13202

Submit by US Mail: Onondaga County Community Development
John H. Mulroy Civic Center, 421 Montgomery St, Syracuse, NY 13202

Name _____

Street Address _____

_____

City, State, Zip _____

Cell Phone _____ **Other Phone** _____

Email Address _____ **Also Contact** _____

OWNERSHIP: (Tenants, please provide owner's name, address, phone number, and email)

Owner's Name/Phone/Email _____

Owner's Address _____

Do you have a mortgage? Y ☐ N ☐ **Name of Lender:** _____

Do you have Homeowner's Insurance? Y ☐ N ☐ **Name of Insurance Provider:** _____

OCCUPANTS

***Including yourself first,* list each person living in the residence.**

Name (list yourself first):	Relationship to applicant:	Date of Birth:	Gender: M F OTHER	Medicaid? Y N	Full-time Student? Y N
			☐ ☐ ☐	☐ ☐	☐ ☐
			☐ ☐ ☐	☐ ☐	☐ ☐
			☐ ☐ ☐	☐ ☐	☐ ☐
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			☐ ☐ ☐	☐ ☐	☐ ☐
			☐ ☐ ☐	☐ ☐	☐ ☐
			☐ ☐ ☐	☐ ☐	☐ ☐

CHILDREN IN HOUSEHOLD

Do any children under the age of 6 living in the residence? Y ☐ N ☐

If Yes, provide the results of his / her blood lead level test results (results must be within 3 months of application).

Do any children under the age of 6 spend a significant amount of time visiting? Y ☐ N ☐ **How many? #** _____

If Yes to either question, please complete the "Residing / Visiting Child Verification Form" (page 4).

Are any household members pregnant? Y ☐ N ☐

INCOME

Do you receive a Housing Choice Voucher? Y ☐ N ☐

If yes, please provide proof. There is no need to provide further income documentation

Do you file Income Tax? Y ☐ N ☐

If yes, provide a copy of your Federal income tax return

Do you have a checking account? Y ☐ N ☐

Do you have a savings account? ☐ ☐

List all income for each person living in the residence below:

Name	Type of Income / Source	Rate	Annual Amt

TOTAL: _____

For Office Use Only

ASSETS: List all assets, including bank accounts, retirement accounts, real estate (rental properties), etc. Do not include your primary home or vehicle(s).

Type of Asset / Source	Amount / Value

TOTAL: _____

For Office Use Only

How did you hear about our program? _____

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GRANT APPLICATION CERTIFICATION PAGE

Applicant _____

Applicant Address _____

I hereby certify that all of the information I have furnished for this application is given for the purpose of obtaining a property rehabilitation grant and is true and complete to the best of my knowledge and belief. I grant Community Development permission to verify any or all of the information. I further certify that I am the owner and/or occupant of the subject property. I agree not to discriminate based on race, color, creed or national origin in the rehabilitation, sale, lease or rental of this property once improved with the assistance of Community Development funds.

Applicant's Signature _____ Date _____

Applicant's Signature _____ Date _____

The following information is requested by the Federal Government in order to monitor compliance with Federal Laws prohibiting discrimination against applicants seeking to participate in this program. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you in any way. However, if you choose not to furnish it, we are required to note the race/national origin of individual applicants on the basis of visual observation or surname.

Gender: Male ☐ Female ☐ Other ☐

Ethnicity:

Hispanic or Latino Not ☐

Hispanic or Latino ☐

Race: (Mark one or more)

White ☐ Black or African American ☐

American Indian/Alaska Native ☐ Asian ☐

Native Hawaiian or Other Pacific Islander ☐

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RESIDING OR VISITING CHILD VERIFICATION

Please fill out the section that applies to your situation.

Child/children who LIVE with you **(see other section below for children who VISIT you often):**

I _____ certify that _____ , ___/___/___
Applicant — Child's Name — DOB

is a child under the age of six and is **a resident of the property** located at: _____
Address

Additionally, the below listed children are also under the age of six and reside at the above address (only fill if applicable):

_____ ___/___/___ _____ ___/___/___
Child's Name — DOB — Child's Name — DOB

_____ _____ _____
Applicant — Date — Applicant's Relation to Child/Children

Child/children who VISIT often:

I _____ certify that _____ ___/___/___
Applicant — Child's Name — DOB

is a child under the age of six that spends a significant* amount of time visiting the property located at:

_____
Address

Do several children under the age of six spend a significant* amount of time in the home? Y ☐ N ☐

If yes, how many?_____ *

** Significant is defined by HUD's OFFICE OF LEAD HAZARD CONTROL AND HEALTHY HOMES as, "At least two different days within any week, provided that each day's visit lasts at least 3 hours and the combined weekly visits last at least 6 hours. The combined annual visits must last at least 60 hours."*

Sign and Date Application:

_____ _____ _____
Applicant Signature — Date — Applicant's Relation to Child/Children

Are you able to obtain recent blood lead level test results for any of the children listed on this page? Y ☐ N ☐

We recommend that blood lead level test results **within the past 3 months** be included with this application. If you are unable to obtain these results or refuse to do so, please let our office know.

DECLARATION OF NO INCOME

Onondaga County Community Development Division is required to verify all income and assets of anyone residing in the household under this program. To comply with this requirement, we ask your cooperation in supplying the information requested in the Certification below. This information will be held in strict confidence and used only for the purpose of establishing your family's eligibility.

CERTIFICATION

I, _____, do hereby certify that I do **NOT** receive income from **ANY** source. I understand sources of income include***, but are not limited to,*** the following:

Wages/Employment by Other(s)	Retirement Funds
Unemployment Compensation	Alimony/Child Support
Social Security	Income from Assets
Workers Compensation	Pensions
Disability	Annuities
Self-Employment	Union Benefits
SSD/SSI	Family Support

I certify that the foregoing is true, complete and accurate. I authorize Onondaga County Community Development to verify the information contained herein. I also understand that providing false statements or omissions are grounds for disqualification and/or prosecution under the full extent of the law.

_____ _____

Signature Date

ACKNOWLEDGMENT

State of New York)
County Of Onondaga) SS:

On the ____ day of _____ in the year ___ before me, the undersigned, a Notary Public in and for said State, personally appeared _____ _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s) or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

Notary Public

ONONDAGA COUNTY HEALTH DEPARTMENT

STANDING, MULTI-USE AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION- THROUGHOUT PROGRAM

Name of Patient	Date of Birth
Address	Contact Phone Number

I authorize the multiple disclosure & exchange of information from my health record between the two parties listed below, its agents, and business associates to disclose the above-mentioned PHI as described below [Statement required by 164.508(c)(I)(ii)]:

OCHD Program/Provider #1:	Facility/Provider #2:
Name of Facility/Organization OCHD Lead Poisoning Prevention Program	Name of Facility/Organization Onondaga County Community Development
Address 421 Montgomery St 9th Fl Syracuse, NY 13202	Address 335 Montgomery St 2nd Fl Syracuse,NY 13202
Fax Number (315) 435 - 3720	Fax Number (315) 435-3794

The Purpose or need for this disclosure is:

- ☐ Ongoing care throughout OCHD program
- ☐ Other (specify) application asst.

The information to be disclosed from my record includes (check appropriate boxes):

- ☐ Any/All for OCHD Program use
- ☐ Only information related to (specify): required for applic

This authorization is valid for the duration of the OCHD program of which I am a voluntary participant. Authorization will **expire two (2) years from date of signature or at the end of the participation in the program**, whichever comes first. [Statement required by 164.508(c)(I)(i)]:

I understand that I can revoke this permission unless the information has already been provided. I can cancel permission by writing to the Onondaga County Health Department, Attn: Compliance Officer, 421 Montgomery St, Syracuse, NY 13202.

-I understand my PHI may be used/disclosed as set forth by this authorization. [Statement required by 164.508(c)(I)(i)]
-I understand that any information disclosed pursuant to this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure by the entity to whom it was disclosed. [Statement required by 164.508(c)(2)(iii)]
-I understand that I am not required to sign this authorization and that the covered entity may not condition treatment on the signing of this authorization. [Statement required by 164.508(c)(2)(ii)]

I initiate this authorization for disclosure of PHI. I have read and understand this authorization. I know that I may request a copy of it at any time. By signing this authorization, I acknowledge that any agreements I have made to restrict my PHI do not apply to the information released pursuant to this authorization. A photocopy of this information shall be considered as effective and valid as the original. **No alteration of this form will be accepted.**

This authorization is for multiple releases of the information indicated above. It will terminate upon my exit from the program OR two (2) years from the date of my signature below.

SIGNATURE:	DATE:
PRINT (WHO IS SIGNING)	RELATIONSHIP TO PATIENT:

OFFICE USE: EXPIRATION DATE _____