

HOME REPAIR PROGRAM

- **CSBG Client Information Form**
- **Home Repair Application- last 12 months proof of income, current utility bills, proof of ownership (title, deed, or copy of paid property taxes), proof of home insurance**
 - **Home Repair for Elderly (over 60-150%)**
 - **Housing Trust Fund (under 60-35% area median)**
- **Confirmation of Lead Pamphlet**
- **Work Request**
- **LEADS Client Emergency Contact Information**
- **Zero Income Certification**



CSBG/ Client Information Form

E-Mail Address: _____

SS# _____ LAST NAME _____ FIRST NAME _____
 DATE OF BIRTH: _____ ADDRESS _____
 CITY _____ ZIP CODE _____ TELEPHONE () _____

GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE		DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		ETHNICITY <input type="checkbox"/> B. BLACK/AFRICAN AMER. <input type="checkbox"/> H. HISPANIC <input type="checkbox"/> A. ASIAN <input type="checkbox"/> W. WHITE <input type="checkbox"/> N. NATIVE AMER. <input type="checkbox"/> O. OTHER			
EDUCATION <input type="checkbox"/> A. 0-8 <input type="checkbox"/> D. 12 + <input type="checkbox"/> B. 9-12 (NON-GRAD) <input type="checkbox"/> E. UNKNOWN <input type="checkbox"/> C. HS GRAD/GED <input type="checkbox"/> F. COLLEGE GRAD			FOOD STAMPS <input type="checkbox"/> YES <input type="checkbox"/> NO		HEALTH INSURANCE <input type="checkbox"/> A. MEDICAID <input type="checkbox"/> D. SELF-INS <input type="checkbox"/> B. MEDICARE <input type="checkbox"/> E. NONE <input type="checkbox"/> C. PRIVATE <input type="checkbox"/> F. UNKNOWN		
VETERAN <input type="checkbox"/> YES <input type="checkbox"/> NO	# IN HSHLD	FAMILY TYPE <input type="checkbox"/> F. SINGLE PAR/FEMALE <input type="checkbox"/> S. SINGLE <input type="checkbox"/> M. SINGLE PAR/MALE <input type="checkbox"/> C. COUPLE <input type="checkbox"/> T. TWO PARENT <input type="checkbox"/> O. OTHER		HOUSING <input type="checkbox"/> OWN <input type="checkbox"/> RENT <input type="checkbox"/> HOMELESS		CLIENT INCOME <input type="checkbox"/> A. WEEKLY <input type="checkbox"/> D. ANNUAL <input type="checkbox"/> B. BI-WEEKLY <input type="checkbox"/> E. 13 WEEKS <input type="checkbox"/> C. MONTHLY <input type="checkbox"/> AMOUNT:	

SOURCES OF INCOME
 A. EMPLOYMENT C. SOCIAL SECURITY E. DA G. PENSIONS I. OTHER:
 B. UNEMPLOYMENT D. AFDC/TANF F. SSI/SSD H. DISABILITY

SITE: _____

HOUSEHOLD MEMBERS					
SS #					
LAST NAME					
FIRST NAME					
DATE OF BIRTH					
GENDER					
DISABLED					
ETHNICITY					
EDUCATION					
HEALTH INS					
VETERAN					
INCOME: PERIOD					
AMOUNT					
SOURCE					

ID#									
UNITS									
DATE									

	NAME	DATE
INTAKE		
DATA ENTRY		

EQUAL OPPORTUNITY- It is the policy of the agency to offer equal opportunity to all-persons without regard to race, religion, national origin, sex, age, political affiliation or handicap.

COMPLAINT PROCEDURES- If you have a complaint related to the completion of services that you have received from LEADS, you have the right to file an appeal. This appeal must be made within 30 days from the date of services. Please make your appeal in writing to: Terry Boehm, Community Service Director, 160 Wilson Street, Newark, Ohio 43055

I certify that this statement is true and correct to the best of my knowledge and authorize the release of any or all information necessary for verification purposes.

 SIGNATURE OF CLIENT DATE

COMMENTS _____



How can we serve you better?

We Appreciate you're taking time to fill this out. The following information is compiled to complete Community Needs Assessment.

1. Family Type:

- Single Parent Female
- Single Parent Male
- Single
- (2)Two Parent Household
- Couple (No Children)
- Other _____

2. Employment Status:

- Fulltime employment
- Part time employment
- Unemployed
- Temporary Employment
- Seasonal Employment
- Retired
- Other _____

3. What are your top five need of your family:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

4. Have you applied to any other sources for services/assistance

- a. Where? _____
- b. Did you receive assistance? yes ___ no ___
if no, why _____
- c. What Assistance _____

5. How did you first hear about leads and the programs they offer?

- Friends/neighbors/relatives
- Newspaper
- Radio
- Refferal by another Agency _____ other _____ Who? _____

Additional Comments

About You (optional)

Name _____ E-mail _____

LEADS COMMUNITY ACTION AGENCY
EMERGENCY INFORMATION ON CLIENT

CLIENT NAME: _____

EMERGENCY CONTACT PERSON: _____

CONTACT PERSON'S PHONE NUMBER _____

ADDRESS: _____

FUNCTIONAL ABILITIES OF CLIENT (REASON FOR DOING JOB)

DISABLED () LOW INCOME () NO FAMILY TO ASSIST ()

OTHER _____

QUESTIONNAIRE

PLEASE FILL OUT COMPLETELY:

NAME: _____

Approximate Age Of Home _____

Is Your Home: (Circle One)

- A) One Story
- B) Two Story
- C) Mobile Home

- D) More Than One Apartment
- E) Other - Explain _____

Siding Type: (Circle One)

- A) Wood Siding
- B) Aluminum Siding
- C) Vinyl Siding

- D) Brick Siding
- E) Any Insulation In Walls
- F) Other - Explain _____

Basement Type: (Circle One)

- A) Full Basement
- B) Crawl Space
- C) Basement - Crawl Space Combo

- D) No Basement
- E) Other - Explain _____

Attic Type: (Circle One)

- A) Full Attic
- B) Floored Attic
- C) Walk Up Attic

- D) Knee Wall Attic
- E) Any Insulation In Attic
- F) Other - Explain _____

Roof Condition Type: (Circle One)

- A) Does Roof Leak
- B) Slate Roof
- C) Metal Roof

- D) Shingle Roof
- E) Other - Explain _____

Heating System:

Fuel Type _____ Make of Furnace _____

When Was The Last Time Your Furnace Was Serviced _____

Is Your Furnace Or Heating System Working Properly _____

Anything Else We Should Know About Your Heating System _____

Cook Stove Type _____ Hot Water Heater Type _____

Anything Else We Should Know About Your Home: _____

I Hereby Agree To Permit LEADS Community Action Agency or Their Representative To Enter The Premises At: _____

To Do Any Necessary Work.

Signature: _____ Date: _____

LEADS

A COMMUNITY ACTION AGENCY

Kenneth A. Kempton
Chief Executive Officer

159 Wilson St.
Newark, Ohio 43055
Phone: (740) 349-8606
Fax: (740) 345-2380

Zero Income Certification

Date _____
Name _____
Address _____

Phone _____
SS# _____

I understand that this affidavit is made as part of the qualification procedure to determine eligibility for residency at _____ apartments and that any misrepresentation herein will be considered a material breach of the lease agreement and subjects to me immediate eviction.

I certify the following:

- _____ I am not currently in any Capacity.
- _____ I have no intention of becoming employed in the next 12 months.
- _____ I do not receive unemployment compensation or other benefits as a result of my non-employed status.

Date of last employment _____

Pervious Employer _____

Address _____

Penalties for missing this content:

Title 18, section 1001 of the U.S. code states that a person is guilty of a felony for knowingly and willing making false or fraudulent statements to any department of the Untied States Government. An owner may be subject to penalties for unauthorized disclosure or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief as the may be appropriate against the officer or employee or the owner responsible for the unauthorized disclosure or improper use.

Signature of tenant/ applicant _____

Dated signed _____

Witness _____

Dated signed _____