Bed Bug Assistance Program

The Cleveland Department of Aging has a new program to help seniors and adults with a disability with limited income with the extermination of bed bugs in their home.

**TO QUALIFY, APPLICANTS:**
- Must meet income guidelines
- Must be 60 years of age or older or an adult 18-59 years receiving a disability payment
- Must own and live in the unit to be treated
- Must reside in the City of Cleveland

**IF YOU QUALIFY, HERE’S WHAT TO DO:**
1. Complete the application on the next page.
2. Provide proof of ownership (ex. copy of water bill).
3. Verify **all** household income
   This program targets low income seniors and adults with a disability based on gross **total household** income. Therefore, participants must verify **current yearly** household income.
   - Social Security Statement- 1-800-772-1213 to request proof
   - If currently employed, two (2) current paycheck stubs
   - If unemployed, copy of unemployment benefits
4. Submit application with supporting documentation to Cleveland Department of Aging at 75 Erieview Plaza, 2nd floor Cleveland OH 44114 or fax to 216.664.2218. Please call us at 216. 664.2833 if you need assistance in completing the application.
5. An inspection will be scheduled to determine the presence of bed bugs and the extermination services required.
6. Preparation of the home for extermination services is required as directed by the extermination service.
7. The City has final approval for the type and numbers of treatments to be provided.

For more information visit [www.city.cleveland.oh.us/aging](http://www.city.cleveland.oh.us/aging)
Application for Assistance with Bed Bugs

Date __________    Ward __________

Owner Occupied:  Yes or No    Is it a single or two family house?________________________
If a two family unit, who resides in second unit?______________________
Applicant’s name ____________________________    Applicant’s birth date ________
Address ____________________________    Zip Code ____________________________
Phone (Home or Mobile) ____________________________    Number of persons in household____
Marital Status ____________________________    Social Security Number (Last 4) ______
Check all appropriate    Asian        Black        White        Native American        Other ________
Are you Hispanic?    Yes         No    Do you own other property?    Yes or No
Do you have any foreclosures/judgments pending?    Yes or No

If approved for services through the Cleveland Department of Aging’s Bed Bug Assistance Program, preparing the home for extermination services is required. Preparation may include; but is not limited to, the follow tasks as directed by the extermination contractor: remove all bedding, disassemble bed frames, remove all materials from bedside tables, and clear closets of clothing.
Are you able to prepare your home for extermination services?    Yes or No
If no, do you have family and/or friends who can help you prepare your home?    Yes or No

Monthly income of Primary applicant
Employment: ____________________________
Social Security: __________
SSI: __________
Pension: __________
VA benefit: __________
Rental income: __________
Other: __________
Total Monthly amount: __________

Secondary applicant (Spouse or person on deed)
Name: ____________________________
Relationship to owner: ____________________________
Birth date: ____________________________
Source of income: ____________________________
Total amount of monthly income: __________

Additional Applicants (Household Members) - Yes or No; If yes, list below

<table>
<thead>
<tr>
<th>Additional Applicant</th>
<th>Additional Applicant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: __________</td>
<td>Name: __________</td>
</tr>
<tr>
<td>Relationship to owner: __________</td>
<td>Relationship to owner: __________</td>
</tr>
<tr>
<td>Source of income: __________</td>
<td>Source of income: __________</td>
</tr>
<tr>
<td>Monthly Amount: __________</td>
<td>Monthly amount: __________</td>
</tr>
</tbody>
</table>

Total Yearly Household Income $ __________

Describe bed bug problem:
____________________________________________________________________

I have answered all questions honestly and to the best of my knowledge. I hereby authorize the City of Cleveland, Department of Aging to obtain verification of necessary financial information and employment as identified on this form.

Applicant’s signature ______________________________________    Date _____
Co-Applicant’s signature ______________________________________    Date _____
City of Cleveland Department of Aging
Permission/Waiver of Liability Agreement

I, ________________________________________________________________, am the owner of the property located at

______________________________________________________________
(Street)  ______________________________________________________
(City)    ______________________________________________________
(Zip Code) ____________________________________________________

I give permission for the City of Cleveland Department of Aging to give my name and address to contractors hired by the City under the Bed Bug Assistance Program and for the contractors to come on my property for the purpose of inspection and bed bug extermination. I release the City of Cleveland from any and all liability, and indemnify and will hold the City of Cleveland, and all governmental units associated with this program, and their respective directors, trustees, officers, employees, agents, representatives and all other personnel from any and all liability, damages, injury, or other harm in conjunction with this program. I agree to follow all applicable rules of the Bed Bug Assistance Program.

__________________________________________________                         ________________
(Signature)                                                   (Date)

__________________________________________________                         ________________
(Witness Signature)                                                    (Date)

Please print:

Name: ________________________________________________________________

Address: ______________________________________________________________

Phone Number: _________________________________________________________

Ward number: _________________________________________________________
I, ________________________________________, (Your name here/ please print) acknowledge that the City of Cleveland, Department of Aging, may find it necessary to share information that I provide such as my name, address, income sources, services I receive and general health status with other agencies. I give my permission for the Department of Aging to share this information for the purpose of helping me receive the service(s) I may need.

I also understand that the information collected will be entered into a confidential client database(s) as required by one or more of the following agencies: Cleveland Department of Aging, Western Reserve Area Agency on Aging and the Ohio Department of Aging.

____________________________________________________________________
(Signature)

____________________________________
(Address)

____________
(Date)

**For staff use only (to be completed when not face to face with a client).**

The above was read to ________________________________________ on           ___

                  (Client’s name)                     (Date)

Client gave verbal consent to release information    Yes    No

I certify that I have received the above verbal authorization:

_______________________________________________________                    ____________
(Department of Aging representative signature)                   (Date)