City of Cleveland
Bed Bug Assistance Program

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

How to Qualify:

1. You must meet income guidelines.
2. You must be 60 years of age or older or an adult, 18-59 years old, receiving a disability payment.
3. You must own and live in the unit to be treated. You must reside in the City of Cleveland.

Family Size	2018 Gross Yearly Income
1	$21,245
2	$28,805
3	$36,365
4	$43,925
5	$51,485
6	$59,045

Subject to Change

For further information and to obtain an application, please contact:

Cleveland Department of Aging
216-664-2833
www.city.cleveland.oh.us/aging

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CITY OF CLEVELAND
Mayor Frank G. Jackson

Revised July 2018

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IF YOU QUALIFY, HERE'S WHAT TO DO:

1. Complete the application on the next page.

2. 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

3. 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.

4. An inspection will be scheduled to determine the presence of bed bugs and the extermination services required.

5. Preparation of the home for extermination services is required as directed by the extermination service.

6. 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

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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

Additional Applicant
Name:_____
Relationship to owner: _____
Source of income: _____
Monthly Amount: $ _____

Additional Applicant
Name: _____
Relationship to owner: _____
Source of income: _____
Monthly amount: $_____

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: _____

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Cleveland Department of Aging Release of Information

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)