Required Documents for Homeowner Service Programs

Applicant Name(s):

Service Address:

Your application cannot be processed without each of the following items below:	**Enclosed**	**N/A**
Copy of your valid, State of Ohio issued Drivers' License [or] State IDs for all homeowner(s).	☐	
Copies of **prior two** (60 Days) full checking, savings, MMA and CD account statements.	☐	
➢ Each Page/Each Account for every adult household member	☐	
(Include pages "Intentionally Left Blank")	☐	
➢ Statements must show institution letterhead including your name and address.	☐	
➢ Statements must include the last four digits of each account number.	☐	
➢ Provide explanation for all deposits of $500 or more.	☐	
➢ Provide statements for all digital, cyber accounts (i.e. CashApp; PayPal; Venmo; etc.)	☐	
➢ **If you have a debit card but NO credit union account or local bank account**, use the phone number on the back of the card to contact the issuer and request monthly statements for the prior two months.	☐	
Copies of current year **2025** full Stock(s); Bond(s); Treasury Bill(s) quarterly/annual	☐	☐
reports. **Copy of current **2025** issued income award letter for each applicable household	☐	☐
member. ➢ Social Security; Disability; Retirement Pension; Public Assistance; VA; Unemployment; Workers Comp; Child Support; Adoption Subsidy; IRA; Keogh etc. **(We cannot accept IRS Form W-2 or 1099 as proof of current year income)**	☐	☐
**Copies of consecutive pay stubs for the prior 30 Days (each adult 18 years and older):	☐	☐
➢ Adults **without income** complete the enclosed Certification of Zero Income (page 7)	☐	☐
Self-Employed ONLY:	☐	☐
Provide prior two (2) years IRS federal income tax filings for each Self-Employed occupant.		
➢ Include both Schedules C and 1.	☐	☐
➢ Include Schedule E for additional properties owned (if applicable).	☐	☐
➢ Fill out Profit and Loss form for each Self-Employed occupant (page 11)	☐	☐
Copy of Columbus City Code Violation Notice (if applicable).	☐	☐
Copy of Military Form DD214 (if applicable).	☐	☐
Applicants for Accessibility Modifications (disabled homeowners and/or occupants)	☐	☐
➢ Physician must complete the enclosed Eligibility Form (page 10).	☐	
➢ Physician must stamp Eligibility Form; provide non-Rx Script [or] letterhead statement.	☐	

INVESTMENT OWNERS ONLY (unit is not the primary residence of the owner)		
Copy of your Photo ID.	☐	
Completed Residential Occupant Profile **(each unit)**(page 4).	☐	
Copy of Columbus City Code Violation Notice, If applicable.	☐	☐
Vacant unit form for **(each unit)** if applicable (page 8).	☐	☐

HOME REPAIR SERVICE REQUESTS

Check (✓) or Mark (X) each item(s) in need of home repair.

☐	Inoperable Furnaces	Accessible Bathtub/Shower	☐
☐	Inoperable Hot Water Tanks	Bathtub Grab Bars	☐
☐	Minor Electrical Repairs	Exterior Chairlift	☐
☐	Plumbing Gaslines	Staircase Handrails	☐
☐	Gutters / Downspouts	Stairlift	☐
☐	Plumbing Drain and Sewerlines	Toilet Assist Railings	☐
☐	Porch / Steps	Wheelchair Ramp	☐
☐	Roof and/or Roof Elements	Widening Doorways for Wheelchair Accessibility	☐
☐	Siding	Carbon Monoxide/Radon	☐
☐	Structural / Foundation	Indoor Air Quality Issues	☐
☐	Windows / Doors	Mold/Moisture	☐
☐	Lead Inspection (If built before 1978)	Pests	☐

Comments: Briefly explain the need for the repairs specified:

To your knowledge, is there an active Columbus City Code Violation written against the property? ☐ **YES** or **NO** ☐

*If yes, please provide a copy of the notice.

How did you hear about this program?

☐	Friend/Family	Columbus Public Health	☐
☐	Community Outreach	City of Columbus Website	☐
☐	Other: _____		

If we learn of other home repair programs available through private sector agencies, do we have your consent to share the contents of this application to make a referral on your behalf? ☐ **YES** or **NO** ☐

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF DEVELOPMENT

APPLICATION FOR HOMEOWNER SERVICES CENTER PROGRAMS

City of Columbus,
Mayor Andrew J. Ginther

Department of Development
Michael H. Stevens, Director

Housing Division
Rita Parise, Administrator

Homeowner Services Center
111 North Front Street, 3rd Floor
Columbus, Ohio 43215

Applicant	(Name)	Married ☐ Unmarried ☐	Separated ☐ Veteran ☐	Male ☐ Female ☐ Other:	
Co-Applicant	(Name)	Married ☐ Unmarried ☐	Separated ☐ Veteran ☐	Male ☐ Female ☐ Other:	

Owner Address: _____
(Street) (Zip Code)

Owner Email: _____

Owner Phone: **Alternate Phone**

If the size of the property being serviced will change within the next 12 months, please explain below:				
Are you or someone in the home that will be serviced pregnant?			☐ **YES** or **NO** ☐	
Is anyone in the home that will be serviced a military veteran?			☐ **YES** or **NO** ☐	
*If yes, please provide a military form DD 214.				
Is there an active mortgage on the serviced property (primary, secondary or home equity loan?)			☐ **YES** or **NO** ☐	
Specify Mortgage Lender:		**Monthly Payment $**		
Is the homeowner insurance coverage paid through your primary mortgage?			☐ **YES** or **NO** ☐	
Does the primary mortgage include your property taxes?			☐ **YES** or **NO** ☐	
Average Utility Payments:	**Monthly Electric $**	**Monthly Gas $**	**Quarterly Water $**	
Occupied by Owner(s)?	☐ **YES** or **NO** ☐	**Vacant property?**	☐ **YES** or **NO** ☐	
Occupied by Tenant(s)?	☐ **YES** or **NO** ☐			
*Attach a separate Residential Occupant Profile sheet (**for each unit**) you wish to enroll in the program.*				
Are you/tenant receiving housing assistance? ☐ **YES** or **NO** ☐ **If so, please specify the type below:**				

RESIDENTIAL OCCUPANT PROFILE: (Owner-occupants or Tenants) If more space is needed, please copy this page while blank and attach it behind page 4.

Address: _____

Phone: _____ **Email:** _____

Race Code: Use the number in front of the appropriate category to complete the chart below.

Definition of "Children Visiting": This includes children under the age of 6 years old that visit the dwelling regularly:
(for at least 2 days/week and 3 hours/day, for at least 60 hours per year).

Per the Fair Housing Act, the definition of disabled is as follows:

- An individual with mental or physical impairments that substantially limit one or more major life activities. The term mental or physical impairment may include conditions such as blindness, hearing impairment, mobility impairment, HIV infection, mental retardation, alcoholism, drug addiction, chronic fatigue, learning disability, head injury, and mental illness. The term major life activity may include seeing, hearing, walking, breathing, performing manual tasks, caring for one's self, learning, speaking, or working. The Fair Housing Act also protects persons who have a record of such an impairment, or are regarded as having such an impairment.
- Current users of illegal controlled substances, persons convicted for illegal manufacture or distribution of a controlled substance, sex offenders, and juvenile offenders are not considered disabled under the Fair Housing Act, by virtue of that status.

First & Last Names starting with **Head of Household,** then list oldest to youngest	**Date of Birth**	**Sex**	**Relation to Head of Household**	**Hispanic or Latino Y or N**	**Race Code See Below for Numbers**	**Disability See Definition Above Y or N**	**Social Security Number(s)**	**Current Blood LEAD level of children (optional)**	**Children visiting See Definition Above Y or N**

Race Codes: Single Race

1) White
2) Black or African American
3) American Indian or Alaskan Native
4) Asian
5) Native Hawaiian

Race Codes: Multi-Race

6) American Indian or Alaskan Native **and** White
7) Asian **and** White
8) Black or African American **and** White
9) American Indian or Alaskan Native **and** Black or African American
10) Other Multi-Race:

Primary Occupant Signature **Date** **Landlord Signature (If applicable)** **Date**

INCOME & ASSETS CHECKLISTS FOR OWNER-OCCUPANTS AND TENANTS ONLY

This section must be filled out by the owner(s) or tenant(s) that are occupying the property. Please check the appropriate boxes for any occupants over the age of 18 that receive any of the following income. Income documentation must be attached for all owner occupant(s).

Income Source(s)	**Name of the Person(s) receiving income (Provide Information)**	**Gross Monthly Amounts Received (Provide Information)**	**Documents Included (Check Box)**
Employment Wages			☐
Self Employed Payroll			☐
Unemployment			☐
Disability Compensation			☐
Workers Compensation			☐
Child Support			☐
Alimony			☐
Cash/Financial Assistance			☐
Social Security, SSI			☐
Pension, Annuity, 401k			☐
Other Income Source:			☐
Household Asset Type(s)	**Person(s) the Asset(s) belong to:**	**Current Value**	**Documents**
Bonds			☐
Capital Investments			☐
Cash Out Surrender Value on Life Ins Policies			☐
Certificate of Deposit [CD]			☐
Individual Retirement IRA			☐
Keogh			☐
Mutual Funds, Money Market (MMA) Accounts			☐
Personal Property held as investment			☐
Rental Property			☐
Stocks			☐
Treasury Bills			☐
Trusts			☐
Other Asset Type:			☐
Provide Type, Recipient information and Current Cash Value below for current year Lump Sum or Single Receipts from an inheritance, capital gains, lottery winnings, insurance settlements or victim's restitution.			
Source			☐

The APPLICANT(s) certifies that all information provided by self/tenant is true and complete to the best of their knowledge. The APPLICANT/TENANTS(s) have listed all known income sources for each adult household member. This application authorizes an evaluation for home repairs, and any misstatement or failure to provide accurate information may result in disqualification and repayment of funds. Verification may be obtained from named sources or a credit report. The City of Columbus Division of Housing may be required to share pictures, inspections, and other information with other City departments when there is a concern for occupant safety. By signing this application, you agree to these terms.

APPLICANT: _____ _____

SIGNATURE of APPLICANT: Date

CO-APPLICAPPLICANT: _____ _____

SIGNATURE of Co-APPLICANT: Date

PENALTY FOR FALSE OR FRAUDULENT STATEMENT: U.S.C. Title 18. Sec 1001, provides: "Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies…or makes any false, litigious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years or both."

Housing Staff Use Only:	SELECT
Alt Program:	Priority Level:
Office Staff Review:	Technician Review:

Certification of Zero Income

(To be completed by adult household members without income. Make extra blank copies if necessary).

Name of person certifying zero income (please print) _____

Date of Birth: _____ **Social Security Number:** _____

_____ Initial

I certify that I do NOT individually receive income or have NOT received income from any of the following sources for the period _____through _____. (If Yes, provide termination letter)

a. Wages from employment (including commissions, tips, bonuses, fees, etc.);
b. Income from operation of a business;
c. Rental income from real or personal property;
d. Interest or dividends from assets;
e. Unemployment or disability payments;
f. Public assistance payments;
g. Periodic allowances such as alimony, child support or gifts received from persons not living in my household;
h. Sales from self-employed resources (Avon, Mary Kay, Amway, Thirty-One, Etc.);
i. Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits;
j. Veteran's Benefits;
k. Supplemental Security Income;
l. Any other source not named above.

_____ Initial

I currently have no income of any kind and there is no imminent change expected in my financial status or employment status during the next 12 months.

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understand(s) that providing false representations herein may constitute an act of fraud.

_____ _____

Signature of person certifying zero income Date

Sworn to before me and subscribed in my presence this _____ day of _____ , 20_____.

_____

Notary Public, State of Ohio

My Commission expires _____

(OFFICE USE ONLY): City of Columbus, Housing Division Representative Signature as Witness in lieu of Notary

VACANT UNIT OCCUPANT STATUS
(only fill this page out if the property unit is vacant)

I/We, _____ the owners of,
(Owner/s Name/s)

_____ verify that the unit is currently
(Property Address)

vacant. To be in compliance with federal regulations that pertain to the **Healthy Homes** program funds, when reviewing applicants, I/we will give priority consideration to those renting to households that are low to moderate income and to households of the disabled and/or elderly age 62 and older. To be in compliance with federal regulations that pertain to the **Lead Safe Columbus** program funds, when reviewing applicants, I/we will give priority consideration to those renting to households that are low to moderate income and to households of families with children age six (6) or under occupying or visiting the unit more than six hours per week.

Signature _____ Date _____

Disclosure Statement

Michael H. Stevens
Director

Rita Parise
Housing Administrator

The City of Columbus Homeowner Service Programs may be federally funded and subjected to many, various rules and regulations. One such regulation may prohibit persons exercising any function or responsibility with respect to Homeowner Service (Programs), or persons in a position to participate in decision-making or to gain inside information from obtaining a personal or financial interest, or other benefit, from the Programs for themselves or for others with whom they have family or business ties. Because the City must comply with such regulation, persons seeking to participate in the Programs must answer a series of questions to determine if a potential conflict of interest exists. If your answer is ***"NO"*** to these questions, you are entitled to participation and possibly assistance from the Homeowner Service Programs. If your answer is ***"YES"*** to any of these questions, your eligibility to participate in the Programs will be determined following a review of the information that you provide.

Disclosure Statements:

A. Are you currently employed by the City of Columbus, Department of Development? ☐ YES or NO ☐
Have you been an employee of the City of Columbus during the past 12 Months? ☐ YES or NO ☐

B. Within the past 12 months, did you have family or business ties with any person who is an employee, consultant, agent, elected official or appointed official of the City of Columbus? ☐ Yes ☐ No.

If you answered yes, please give name(s) and position(s) and your relationship with the person(s).

Name(s)	Position(s)	Relationship(s)

C. Within the past 12 months, have you served as a consultant to the City of Columbus, Homeowner Assistance Program, or any other housing related program administered by the City? ☐ Yes ☐ No

If you answered yes, please provide the nature of the consultant activity: _____

_____

_____

D. I (We), the undersigned, hereby certify that the information provided on this form by me (us) is true and complete to the best of my (our) knowledge and belief:

_____ _____
Property Owner Co-property Owner

_____ _____
Date Date

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR

Home Accessibility Modification Eligibility

Department of Development
Michael H. Stevens, Director

Housing Administrator
Rita Parise

City of Columbus
Housing Division
111 North Front Street, 3rd Floor
Columbus, Ohio 43215
Phone: (614) 645-8526

Case Number/Surname

Service Address

**** This form must be completed by and accompany a Physician/Chiropractor Certification for Prescription ****

The Physician/Chiropractor must sign, date **And Attach** a Certification for Prescription; Office Letterhead [or] apply Office Stamp

HOME ACCESSIBILITY MODIFICATION ELIGIBILITY

Name *(Last, First, M.I.)*	☐ M ☐ F	**DOB:**
Physician/Chiropractor Signature:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

List any diagnosed medical conditions/disabilities:
How long will these medical conditions/disabilities last?

IDENTIFY ONE OR MORE MAJOR LIFE ACTIVITIES THAT ARE SUBSTANTIALLY LIMITED DUE TO THE DISABILITY:

- ☐ Climbing Stairs
- ☐ Walking
- ☐ General Mobility
- ☐ Pulling/Lifting
- ☐ Other (Explanation):

OTHER PROBLEMS

*Mark the boxes below and check whether the following modifications would be medically necessary for an accessible living environment **[or]** of helpful benefit to the client.* ***Transfer the marked items below to a Non-Rx Prescription; Office Letterhead [or] apply Office Stamp***

MOBILITY MODIFICATIONS	MOBILITY MODIFICATIONS	
☐ Grab Bars	Stair Lifts	☐
☐ Wheelchair Ramp	Widening Doorways	☐
☐ Handrails for Steps	Toilet Assist Railings	☐
☐ Accessible Bath/Shower	Other (Explanation Below) Cabinet/Stove Accessibility, etc	☐
☐ Chair Lifts		

Service Address: **Project/Case #:**

PROFIT AND LOSS STATEMENT

This form must accompany federal IRS tax filings for the prior two (2) years or complete an IRS form 4506-T.

Please complete a separate Profit and Loss Statement for each business owned by the borrower/grantee(s). This document is provided as a sample; though, the answers to the questions below are necessary in determining income eligibility.

Company Name: _____

Type of Business: _____

For the Period: _____ through _____
DD/MM/YYYY DD/MM/YYYY

Income:	Gross Sales and Receipts	
Other Income:	Other Income (e.g. interest, fees earned, etc.)	
	Total Income (Gross Sales plus Other Income)	
Business Only Expenses:	Salaries Paid to Owners (other than to me/us)	
	Benefits to Owners/Employees (other than to me/us)	
	Payroll Taxes	
	Business Utilities	
	Insurance	
	Advertising	
	Telephone	
	Office Expenses	
	Repairs and Maintenance	
	Business Travel, Meals and Entertainment	
	Materials/Labor	
	Other Business Expenses	
	Total Business Expenses	
Net Income/Loss:		

This form accurately states my /our business expenses and self-employed income for the stated period.

_____ _____
Owner/Operator Signature Date

_____ _____
CPA Signature (if applicable) Date