Bed Bug Assistance Program

The Cleveland Department of Aging has a 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. 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.clevelandohio.gov
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 following 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  Secondary applicant (Spouse or person on deed)
Employment:  $_________  Name:_______________________________
Social Security:  $_________  Relationship to owner:  ___________
SSI:  $_________  Birth date: ________________________
Pension:  $_________  Source of income: ______________________
VA benefit:  $_________  Total amount of monthly income: $ ________
Rental income:  $_________  
Other:  $_________  
Total Monthly amount:  $_________

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

Additional Applicant  Additional Applicant
Name:_________________________  Name:_________________________
Relationship to owner:  __________  Relationship to owner:  __________
Source of income:  _______________  Source of income:  _______________
Monthly Amount: $ ___________  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: __________________________________________

Revised July 2023
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)