Health and Safety Client Intake Survey

Client Name:_____ **File ID**:_____

Address:_____

Date of Initial Survey:____/____/_____ **Date of Onsite Survey**:____/____/_____

The New Jersey Weatherization Assistance Program (NJ WAP) assists low-income homeowners and tenants with making their homes more energy efficient, thereby increasing their comfort and saving money on energy bills. In the process, we work to ensure their health and safety to the best of our ability.

As a client in the NJ WAP, I understand that my health and safety, and that of the NJ WAP staff and contractors is a critical component of the NJ WAP and that any and all weatherization activities, retrofit materials, techniques or practices will be conducted to minimize any health and safety concerns and negative environmental impacts.

To be completed at client eligibility intake and confirmed with follow up during home assessment.
To provide safe and effective services, it is necessary to understand occupant health conditions and potential health concerns within the home. Please check the appropriate boxes below and provide details in the space provided.

☐ Has anyone in the household tested positive for COVID-19? ☐ yes or ☐ no
If yes, how long ago? _____
☐ Has anyone in the household experienced fever, cough or shortness of breath in the last two weeks?
☐ yes or ☐ no
☐ Has anyone in the household been in contact with someone who has tested positive or experiencing the above symptoms? ☐ yes or ☐ no If yes, how long ago_____
☐ Does anyone in the household have underlying medical conditions or are they in frequent contact with someone who has underlying medical conditions? ____yes or ____no
☐ Chronic allergies:_____
☐ Breathing problems:_____
☐ High blood lead levels:_____
☐ Wheelchair or accessibility needs: _____
☐ Mold or moisture problems in home (specify location): _____
☐ Lead or asbestos in home (specify location): _____
☐ Known radon test levels:_____
☐ Other concerns:_____

Identified actions that may be necessary to assure the health and safety of clients based on occupant preexisting health conditions (auditor note the planned use spray foam and any additional precautions to be taken):

Intake Specialist Signature: _____ **Date**:____/____/_____

Auditor/Assessor Signature: _____ **Date**:____/____/_____

Please contact your local WAP agency if you have any questions or concerns about the work being performed in your home.