



SEUALG Weatherization Assistance Program

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APPLICANT HEALTH AND SAFETY EVALUATION

Applicant Name:

Application Number:

Client Pre-Weatherization Assessment of Home Health and Safety: To be completed by the client and submitted as part of the Weatherization Assistance Application. Please answer all questions as accurately as possible.

1. Do you have mold or mildew problems in your home, or do you experience high humidity at any time of the year? Yes No

If Yes, please describe location & time of year _____

2. Is the basement or crawl space below your home frequently damp or wet? Yes No

3. Please check if you typically store any of the following items *inside* your home:

- | | | | |
|-----------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Gasoline | <input type="checkbox"/> Solvents | <input type="checkbox"/> Pesticides | <input type="checkbox"/> Space Heaters |
| <input type="checkbox"/> Kerosene | <input type="checkbox"/> Grease | <input type="checkbox"/> Herbicides | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Paints | <input type="checkbox"/> Oil | <input type="checkbox"/> Gas Powered Equipment | <input type="checkbox"/> None |

4. Please check if any member of your household is experiencing any of the following symptoms:

- | | | | |
|---|---|--|-------------------------------|
| <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Chronic drowsiness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> None |
| <input type="checkbox"/> Burning or watery eyes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Repeated Nausea | |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Other: _____ | |

Answer the following *if* a member of your household is experiencing symptoms:

a. Number of household member(s) experiencing symptoms _____

b. List the age of the household member(s) experiencing symptoms _____

c. During which season are symptoms most severe:

- Spring Summer Fall Winter No difference

d. Symptoms are most severe in household members who spend most of their time

- Inside the home Outside Away from the home No difference

5. Check if any of the following things have occurred at your home in the last 2 years:

- | | | |
|---|---|--|
| <input type="checkbox"/> New Construction | <input type="checkbox"/> New Carpets | <input type="checkbox"/> Changes to your Water Heater |
| <input type="checkbox"/> Extensive Remodeling | <input type="checkbox"/> New Draperies, or furniture | <input type="checkbox"/> New Wood Stove |
| <input type="checkbox"/> Painting | <input type="checkbox"/> Changes to your heating system | <input type="checkbox"/> Changes to your existing wood stove |

6. Is there anything else about your home that you suspect may contribute to poor indoor air quality, excessive moisture, or be a physical hazard to the occupants? Please explain: _____

7. I have answered the above questions to the best of my knowledge.

Applicant Signature: _____

Date: _____

