



## OHIO DEPARTMENT OF HEALTH

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246 North High Street  
Columbus, Ohio 43215

614/466-3543  
[www.odh.ohio.gov](http://www.odh.ohio.gov)

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John R. Kasich/Governor

Lance Himes/Director of Health

December 21, 2017

I am happy to share that the Ohio Department of Health (ODH), in partnership with the Ohio Department of Medicaid (ODM), has secured **\$9 million in funding for lead hazard control in properties**. ODH has hired a third party vendor, Better Healthy Environments (BHE), who will provide daily oversight and monitoring of this statewide project.

This funding will be used to control lead hazards in properties that are known to have poisoned at least one child. If you would like to participate in the project and would like to bid on lead hazard control projects, please complete the enclosed application. You should identify the areas in which you are interested in working and provide all required attachments to ODH.

Note that a complete application with all attachments is needed before your name will be added to the project's abatement contractor list. As jobs in your desired area(s) become available, BHE will email you the request for quotation to complete and return. All bids will be awarded to the lowest responsive and responsible bidder.

We look forward to working with many contractors to make this project a success. Please contact Dania Nixon at 614-387-1289 or [danianixon@odh.ohio.gov](mailto:danianixon@odh.ohio.gov) with questions regarding the project or the enclosed documents.

Sincerely,

Pam Blais  
Project Director  
Ohio Department of Health

**CONTRACTOR'S APPLICATION QUESTIONNAIRE**

**Please type or print clearly. Return via fax to 614-728-6793 or via e-mail to Dania.nixon@odh.ohio.gov.**

COMPANY NAME: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_

LC# \_\_\_\_\_ EXP. DATE \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

FIRM'S YEARS IN EXISTENCE \_\_\_\_\_

HOW MANY JOBS CAN YOU HANDLE AT ONE TIME? \_\_\_\_\_

NAME(S) OF LEAD WORKERS EMPLOYED: (ATTACH ADD'L SHEET, IF NEEDED)

NAME \_\_\_\_\_ LW# \_\_\_\_\_ EXP. DATE \_\_\_\_\_

NAME \_\_\_\_\_ LW# \_\_\_\_\_ EXP. DATE \_\_\_\_\_

NAME \_\_\_\_\_ LW# \_\_\_\_\_ EXP. DATE \_\_\_\_\_

RRP INDIVIDUAL CERTIFICATE NUMBER\*\* \_\_\_\_\_

RRP FIRM CERTIFICATE NUMBER\*\* \_\_\_\_\_ EXP. DATE \_\_\_\_\_

NAME OF GENERAL LIABILITY COMPANY \*\* \_\_\_\_\_

NAME OF GENERAL LIABILITY AGENT \*\* \_\_\_\_\_

PHONE NUMBER OF AGENT \_\_\_\_\_

LIMITS OF LIABILITY  
GENERAL LIABILITY \*\* \_\_\_\_\_ VEHICLE LIABILITY \*\* \_\_\_\_\_

DO YOU CARRY WORKER'S COMPENSATION \*\* YES \_\_\_\_\_ NO \_\_\_\_\_

CERTIFICATE NUMBER \*\* \_\_\_\_\_

FEDERAL ID # \_\_\_\_\_ OR SOCIAL SECURITY# \_\_\_\_\_

BANK NAME: \_\_\_\_\_

WOULD YOU PREFER PAYMENTS BE MADE ELECTRONICALLY TO YOUR BANK?

YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES: BANK ROUTING NUMBER \_\_\_\_\_

CHECKING ACCOUNT NUMBER \_\_\_\_\_

**RECENT JOBS COMPLETED**

NAME \_\_\_\_\_ CONTACT PERSON \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

DOLLAR AMOUNT AND TYPE OF WORK \_\_\_\_\_

NAME \_\_\_\_\_ CONTACT PERSON \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

DOLLAR AMOUNT AND TYPE OF WORK \_\_\_\_\_

I, \_\_\_\_\_, HEREBY GIVE PERMISSION TO THE OHIO DEPARTMENT OF HEALTH OR ITS WORKING PARTNERS TO CONTACT ANY OR ALL OF THE ABOVE NAMED PARTIES.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**\*\* MUST SUBMIT COPY OF ALL CERTIFICATIONS WITH APPLICATION (RRP INDIVIDUAL AND FIRM CERTIFICATES, CERTIFICATE OF LIABILITY INSURANCE, AND CERTIFICATE OF OHIO WORKERS' COMPENSATION CERTIFICATE, IF APPLICABLE)**

Please circle all the following Ohio Counties in which you would like to work:

ALL (if you would like to work statewide)

