APPENDIX A

New Jersey Department of Health
Child and Adolescent Health Program
PO Box 364
Trenton, NJ 08625-0364

HAZARD ASSESSMENT QUESTIONNAIRE FOR INVESTIGATION OF CHILDREN WITH ELEVATED BLOOD LEAD LEVELS

Name(s) of Individual(s) Administering Questionnaire *(Print)*	Title(s)
Signature(s)	Date of Completion

The results of this questionnaire will be used for two purposes:

- To determine where environmental samples should be collected.
- To develop corrective measures related to use patterns and living characteristics (e.g., flushing the water line if water lead levels are high, increase cleanliness of dwelling).

The administrator(s) of this questionnaire should always recommend temporary measures to immediately reduce the child's exposure to lead hazards.

GENERAL INFORMATION		
Dwelling Address	Apt. #	Floor #

Where do you think the child is exposed to the lead hazard? *[Specify location(s)]*:

Do you rent or own your home?

☐ Rent ☐ Own

If rent, does the family receive any rent subsidies?

☐ Yes ☐ No

If Yes, what type

☐ Public Housing Authority – Name of housing authority: _____
☐ Section 8
☐ Federal rent subsidy
☐ Other: _____

Landlord Information (or Rent Collector Agent)
(Include all means of contacting the property owner, including fax number, email address, cell phone/beeper number)

Name: _____

Address: _____

Telephone Number: _____

Fax Number: _____

Cell Phone/Beeper Number: _____

Email Address: _____

In what country was the child born?

☐ USA
☐ US Territory (Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, etc.)
☐ Other: _____
☐ Don't know
☐ Decline to answer

HAZARD ASSESSMENT QUESTIONNAIRE
(Continued)

Complete the following for all addresses where the child currently lives and has lived during the past three (3) months.

Dates of Residency *(MM/YYYY to MM/YYYY)*	Street Address, City, State	Year Dwelling Built	Single Family or Multi Unit	General Condition of Dwelling	Any Remodeling or Renovation? *(Yes or No)*	Any Deteriorated Paint? *(Yes or No)*

Complete the following for all addresses where the child currently or has been cared for, away from home, during the past three (3) months.

Dates of Care *(MM/YYYY to MM/YYYY)*	Type of Care*	Name of Contact, Street Address, City, State, Telephone Number	Number of Hours Per Week	General Condition of Structure	Any Remodeling or Renovation? *(Yes or No)*	Any Deteriorated Paint? *(Yes or No)*

**Type of care includes: preschool, child care center, child care home, care provided by a relative or friend.*

Complete the following for all times the child spent outside of the US. This includes any traveling, visiting family or friends, or living in another country. Start with the most recent.

#	Country	When did child stay there (start with most recent)? (Month/Year)	How long did child stay?		Comments
			Weeks	Months	
1					
2					
3					

Lead-Based Paint and Lead-Contaminated Dust Hazards

Approximately what year was this dwelling built?

To your knowledge, has this dwelling ever been tested for lead-based paint or lead-contaminated dust?

☐ Yes ☐ No

If Yes, when and from whom can this information be obtained? _____

_____

To your knowledge, has there been any recent repainting, remodeling, renovation, window replacement, sanding, or scraping of painted surfaces inside or outside this dwelling unit?

☐ Yes ☐ No

If Yes, when and from whom can this information be obtained? _____

_____

HAZARD ASSESSMENT QUESTIONNAIRE
(Continued)

Lead-Based Paint and Lead-Contaminated Dust Hazards, Continued

Where does the child like to play, hide, or frequent?

Areas * Where Child Likes to Play, Hide or Frequent	Paint Condition ** (Intact, Fair, Poor, or Not Present)	Location of Painted Component with Visible Bite Marks

* Include rooms, closets, porches, outbuildings.

** Paint condition: Note location and extent of any visible chips and/or dust in window wells, on window sills, or on the floor directly beneath windows. Do you see peeling, chipping, chalking, flaking, or deteriorated paint? If yes, note locations and extent of deterioration.

Water Lead Hazards

What is the primary source of drinking water for the child?

☐ Municipal ☐ Private Well ☐ Bottled ☐ Other

If Other, specify: _____

If tap water (source is municipal/private well) is used for drinking, please answer the following:

a. From which faucets do you obtain drinking water (locations): _____

_____

b. Do you use the water immediately from the faucet? ☐ Yes ☐ No

c. Is water used to prepare infant formula, powdered milk, or juices for the child? ☐ Yes ☐ No

If Yes, do you use hot or cold water? ☐ Hot ☐ Cold

If No, from what source do you obtain water for the child? _____

d. To your knowledge, has new plumbing been installed within the last 5 years? ☐ Yes ☐ No

If Yes, identify location(s): _____

e. Was any of this work installed by yourself or another resident of the home? ☐ Yes ☐ No

If Yes, specify: _____

f. To your knowledge, has the water ever been tested for lead? ☐ Yes ☐ No

If Yes, where can test results be obtained? _____

Lead in Soil Hazards

Where outside does the child like to play, hide or frequent?

_____

a. Is there bare soil where the child likes to play, hide or frequent? ☐ Yes ☐ No

b. Is this dwelling located near a lead-producing industry (e.g., battery plant, smelter, radiator repair shop, or electronics/soldering industry)? ☐ Yes ☐ No

If Yes, specify: _____

Lead in Soil Hazards, Continued

c. Is the dwelling located within two blocks of a major roadway, freeway, elevated highway, or other transportation structures? ☐ Yes ☐ No

If Yes, specify: _____

d. Are nearby buildings or structures being renovated, repainted or demolished? ☐ Yes ☐ No

If Yes, location: _____

e. Is there deteriorated paint on porches, fences, garages, play structures, railings, building siding, windows, trims, or mailboxes? ☐ Yes ☐ No

If Yes, location(s): _____

f. Was gasoline or other solvents ever used to clean parts or disposed of at the property? ☐ Yes ☐ No

g. Are there visible paint chips near the perimeter of the house, fences, garages, or play structures? ☐ Yes ☐ No

If Yes, location(s): _____

h. Has the soil ever been tested for lead? ☐ Yes ☐ No

If Yes, from whom can this information be obtained? _____

i. Have you burned painted wood in a woodstove or fireplace? ☐ Yes ☐ No

If Yes, have you emptied ashes onto soil? ☐ Yes ☐ No

If Yes, location: _____

Occupational/Hobby Lead Hazards

Occupations and hobbies that may cause lead exposure include the following:

- Paint removal (including sandblasting, scraping, abrasive blasting, sanding, or using a heat gun or torch)
- Working in a chemical plant, a glass factory, an oil refinery, or any other work involving lead
- Remodeling, repairing, or renovating dwellings or buildings, or tearing down buildings or metal structures (demolition)
- Creating explosives or ammunition
- Plumbing
- Repairing radiators
- Making batteries
- Chemical strippers
- Melting metal for reuse (smelting)
- Welding, burning, cutting, or torch work
- Making paint or pigments
- Auto body repair work
- Pouring molten metal (foundries)
- Salvaging metal or batteries
- Working at a firing range
- Making or repairing jewelry
- Making or splicing cable or wire
- Building, repairing, or painting ships
- Painting
- Making pottery

Where do adult family members work (include mother, father, older siblings, other adult household members)?

Name	Place of Employment	Occupation or Job Title

HAZARD ASSESSMENT QUESTIONNAIRE
(Continued)

Occupational/Hobby Lead Hazards, Continued

				Comments
1.	Are work clothes washed with other laundry?	☐ Yes	☐ No	
2.	Has anyone in the household removed paint or varnish while in the dwelling? (paint removal from woodwork, furniture, cars, bicycles, boats)	☐ Yes	☐ No	
3	Has anyone in the household soldered electric parts while at home?	☐ Yes	☐ No	
4.	Does anyone in the household apply glaze to ceramic or pottery objects?	☐ Yes	☐ No	
5	Does anyone in the household work with stained glass?	☐ Yes	☐ No	
6.	Does anyone in the household use artist paints to paint pictures or jewelry?	☐ Yes	☐ No	
7.	Does anyone in the household reload bullets, target shoot, or hunt?	☐ Yes	☐ No	
8.	Does anyone in the household melt lead to make bullets or fishing sinkers?	☐ Yes	☐ No	
9.	Does anyone in the household work in auto body repair at home or in the yard?	☐ Yes	☐ No	
10.	Is there evidence of take-home work exposures or hobby exposures in the dwelling?	☐ Yes	☐ No	

Child Behavior Risk Factors

				Comments
1.	Does child suck his/her fingers?	☐ Yes	☐ No	
2.	Does child put painted objects into his/her mouth? (If Yes, specify under Comments)	☐ Yes	☐ No	
3.	Does child chew on painted surfaces, such as old painted cribs, window sills, furniture edges, railings, door molding, or broom handles? (If Yes, specify under Comments)	☐ Yes	☐ No	
4.	Does child chew on putty around windows?	☐ Yes	☐ No	
5.	Does child put soft metal objects in his/her mouth (lead and pewter toys and toy soldiers, jewelry, gunshot, bullets, beads, fishing sinkers, or any items containing solder)?	☐ Yes	☐ No	
6.	Does child chew or eat paint chips or pick at painted surfaces?	☐ Yes	☐ No	
7.	Is the paint deteriorated in the child's play areas?	☐ Yes	☐ No	
8.	Does the child put foreign-printed material (newspapers, magazines) in his/her mouth?	☐ Yes	☐ No	
9.	Does the child put matches in his/her mouth?	☐ Yes	☐ No	
10.	Does the child play with cosmetics, hair preparations, or talcum powder or put them into his/her mouth?	☐ Yes	☐ No	
	a. If yes, are any of these foreign made?	☐ Yes	☐ No	
11.	Does the child have a favorite cup? (If Yes, specify under Comments)	☐ Yes	☐ No	

Child Behavior Risk Factors, Continued

12. Does the child have a favorite eating utensil? (If Yes, specify under Comments) ☐ Yes ☐ No _____

13. Does the family have a dog, cat, or other pet that could track in contaminated soil or dust from the outside? ☐ Yes ☐ No _____

    a. If yes, where does the pet sleep? _____

14. Does the child take baths in an old bathtub with deteriorated or nonexistent glazing? ☐ Yes ☐ No _____

Other Household Risk Factors

Complete the table below for the following imported products used by, used on or given to the child during the past 12 months.

Sources can include products:

- sent/given to you by friends and/or family
- bought in local stores
- brought back from trips you may have taken
- prescribed by alternative medicine practitioner

Product Type	Used		Product Name	Country of Origin	Comments *(include form of the product such as powder, pill, used as a tea)*
	Yes	No			
Cosmetics (including kohl, surma, ceruse)					
Home remedies/folk medicines (including teething, colic, fever, stomachaches or diarrhea)					
Alternative medicine or herbal treatments					
Ayurvedic medicines (based on traditional Asian Indian medical system)					
Vitamins					
Liquids prepared, served and/or stored in metal, pewter, glazed, soldered, or crystal containers					
Foods prepared, served, and/or stored in metal, pewter, glazed, soldered, or crystal containers					
Deodorant (i.e., litargirio)					
Spices					
Snacks or candies (including candy spiced with chili, tamarind, sold in clay pots)					

HAZARD ASSESSMENT QUESTIONNAIRE
(Continued)

Other Household Risk Factors, Continued

Does the child play in, live in, or have access to any areas where the following materials are kept?

Item	Yes	No		Yes	No		Yes	No
Shellacs			Epoxy Resins			Gasoline		
Lacquers			Putty			Paints		
Driers			Industrial Crayons or Markers			Old Batteries		
Coloring Pigments			Fishing Sinkers			Battery Casings		
Pipe Sealants			Solder			Lead Pellets		
Drapery Weights			Fungicides			Pesticides		
Detergents			Gear Oil			Gasoline		

Does the child eat, chew on, or put other non-food items into his/her mouth (i.e., toys, mini-blinds, crayons, candy wrappers, jewelry)?

#	Item Name/Description	Country of Manufacturer	How Often?
1			_____ times per _____
2			_____ times per _____
3			_____ times per _____
4			_____ times per _____

Assessment of Hazard Control Measures

What cleaning equipment does the family have in the dwelling?

☐ Broom ☐ Mop and Bucket ☐ Vacuum (Does it work? ☐ Yes ☐ No) ☐ Sponges and Rags

Room	Type of Floor Covering [vinyl/linoleum, carpeting, wood, other (specify)]	Smooth and Cleanable (Yes or No)	Type of Cleaning (sweep, wet mop, vacuum)	Frequency of Cleaning (daily, weekly, monthly)	General Cleanliness *
Entry/foyer					
Living Room					
Dining Room					
Kitchen					
Child's Bedroom					
Bathroom					

* General cleanliness of the dwelling interior:

1 = appears clean 2 = some evidence of housecleaning 3 = no evidence of housecleaning

How frequently are window sills cleaned?	How frequently are window troughs cleaned?

APPENDIX B

New Jersey Department of Health
Child and Adolescent Health Program
PO Box 364
Trenton, NJ 08625-0364

ENVIRONMENTAL INTERVENTION REPORT

Date Investigation Started			Year of Construction
Street Address	Floor #	Apt. #	Number of Children in Residence
City	Zip Code		Number of Children in Residence 0-2 Years Old
Name of Owner			Telephone Number of Owner
Address of Owner			

XRF Serial Number

Name of Laboratory *(when samples are sent to a reference laboratory)*	Laboratory License Number*(when samples are sent to a reference laboratory)*

- Checklist of Required Documents to be attached to this report:

  ☐ Laboratory Report Sheets ☐ Diagrams of the Dwelling ☐ XRF Printouts

Local Health Department Name	
Name of Inspector	NJDOH License Number
Signature of Inspector	Date Investigation Completed

ENVIRONMENTAL INTERVENTION REPORT (Continued)

XRF TESTING

Street Address	Floor #	Apt. #	Inspector's Initials
City		Zip Code	

Room Name	Room Number	Wall (A, B, C, D)	Component	Location (L, C, R) or Component Number **	Sub Component	Substrate	Paint Condition (Good, Fair, Poor)	XRF Reading * (mg/cm^2)	Violation? (x)	Treatment Method (Abatement or Interim Controls)

*** XRF Printouts must be attached** **** Location = Left, Center or Right**

Component number is for multiple components on the same wall. It consists of the wall designation (A, B, C, D) plus the component's number from left to right (A1, A2, etc.).

ENVIRONMENTAL INTERVENTION REPORT (Continued)

DUST WIPES TESTING

Street Address	Floor #	Apt. #	Inspector's Initials
City		Zip Code	

Room Name/ Number	Component	Location (L, C, R) or Component Number **	Sub Component	Substrate	Paint Condition (Good, Fair, Poor)	Violation? (x)	Treatment Method (Abatement or Interim Controls)
/							
/							
/							
/							
/							
/							
/							
/							
/							
/							

*** Laboratory reports must be attached ** Location = Left, Center or Right**

Component number is for multiple components on the same wall. It consists of the wall designation (A, B, C, D) plus the component's number from left to right (A12, A2, etc.).

ENVIRONMENTAL INTERVENTION REPORT (Continued)

MISCELLANEOUS TESTING *

Street Address	Floor #	Apt. #	Inspector's Initials
City		Zip Code	

Soil / Water / Other	Sample Location / Type	Instrument Test Results	Reference Laboratory Test Results *	Violation? (x)	Treatment Method (Abatement or Interim Controls)

*** Laboratory reports must be attached.**

ENVIRONMENTAL INTERVENTION REPORT (Continued)

PAINT CHIP TESTING *
(IF APPLICABLE)

Street Address	Floor #	Apt. #	Inspector's Initials
City		Zip Code	

Room Name/ Number	Wall (A, B, C, D)	Component	Location (L, C, R) or Component Number **	Sub Component	Substrate	Paint Condition (Good, Fair, Poor)	Violation? (x)	Treatment Method (Abatement or Interim Controls)
/								
/								
/								
/								
/								
/								
/								
/								

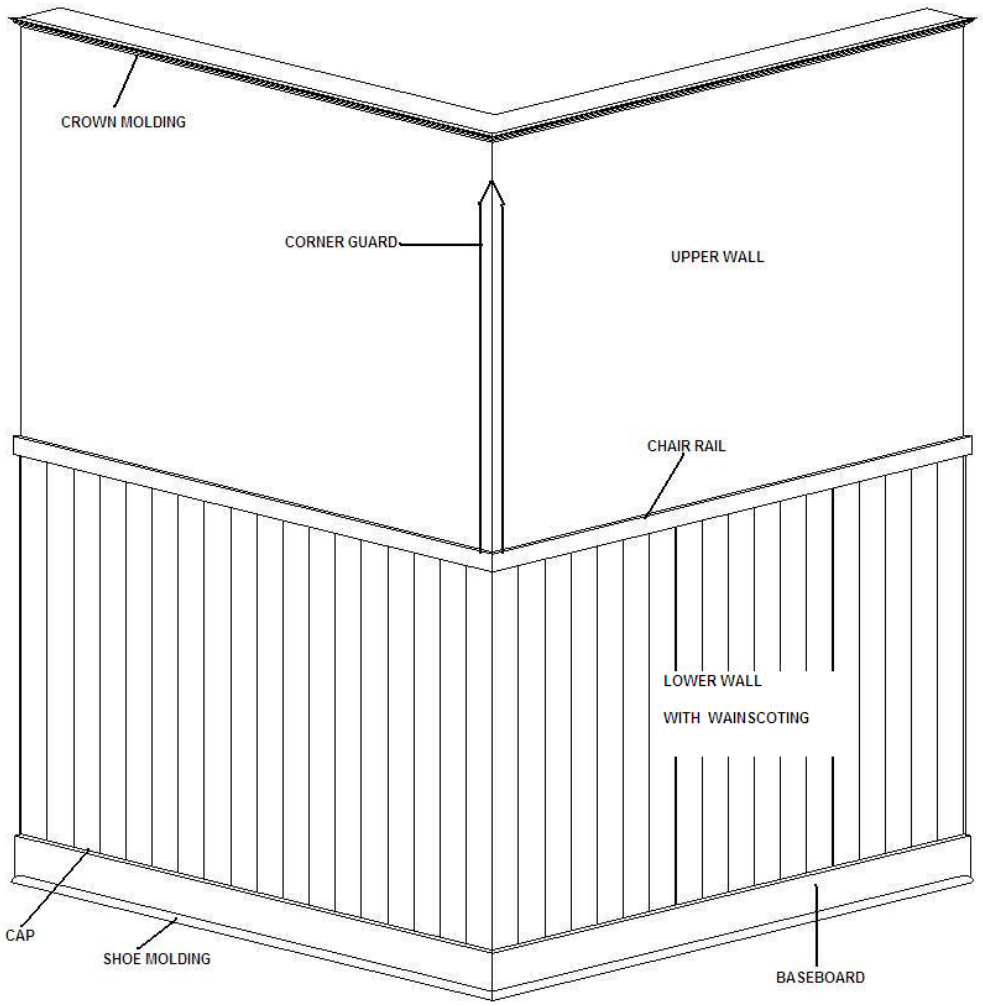
* Laboratory reports must be attached ** Location = Left, Center or Right

Component number is for multiple components on the same wall. It consists of the wall designation (A, B, C, D) plus the component's number from left to right (A1, A2, etc.)

APPENDIX C

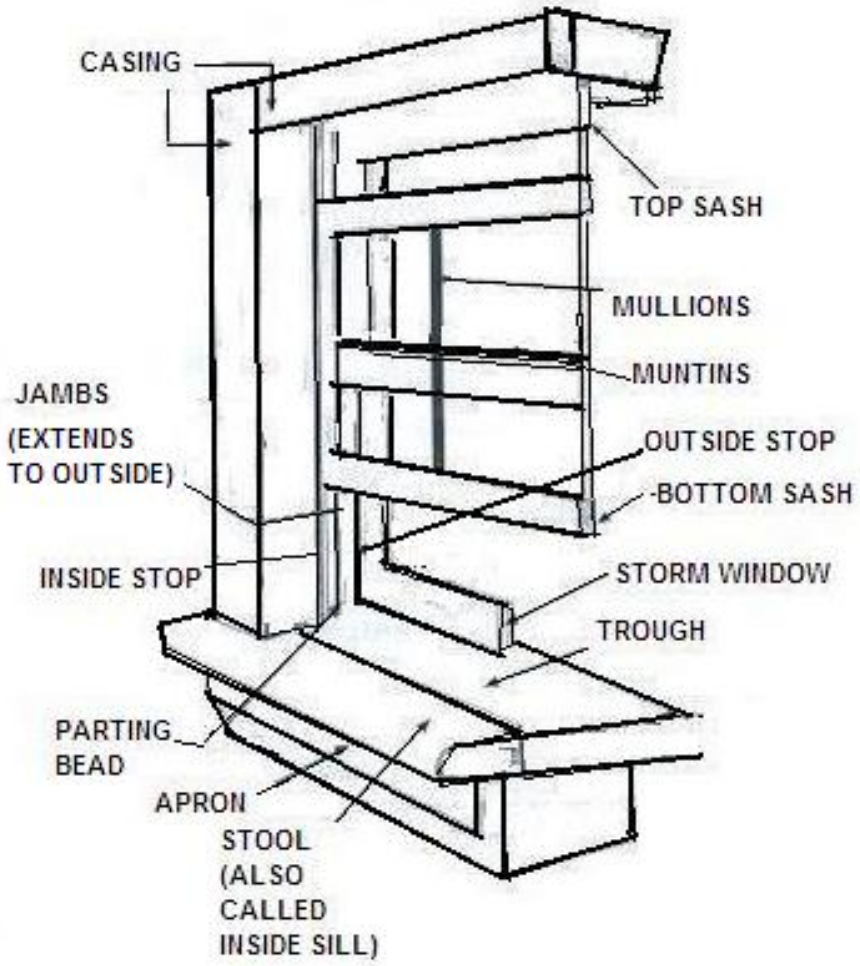
New Jersey Department of Health
Child and Adolescent Health Program
PO Box 364
Trenton, NJ 08625-0364

STANDARD HOUSING COMPONENT TERMINOLOGY



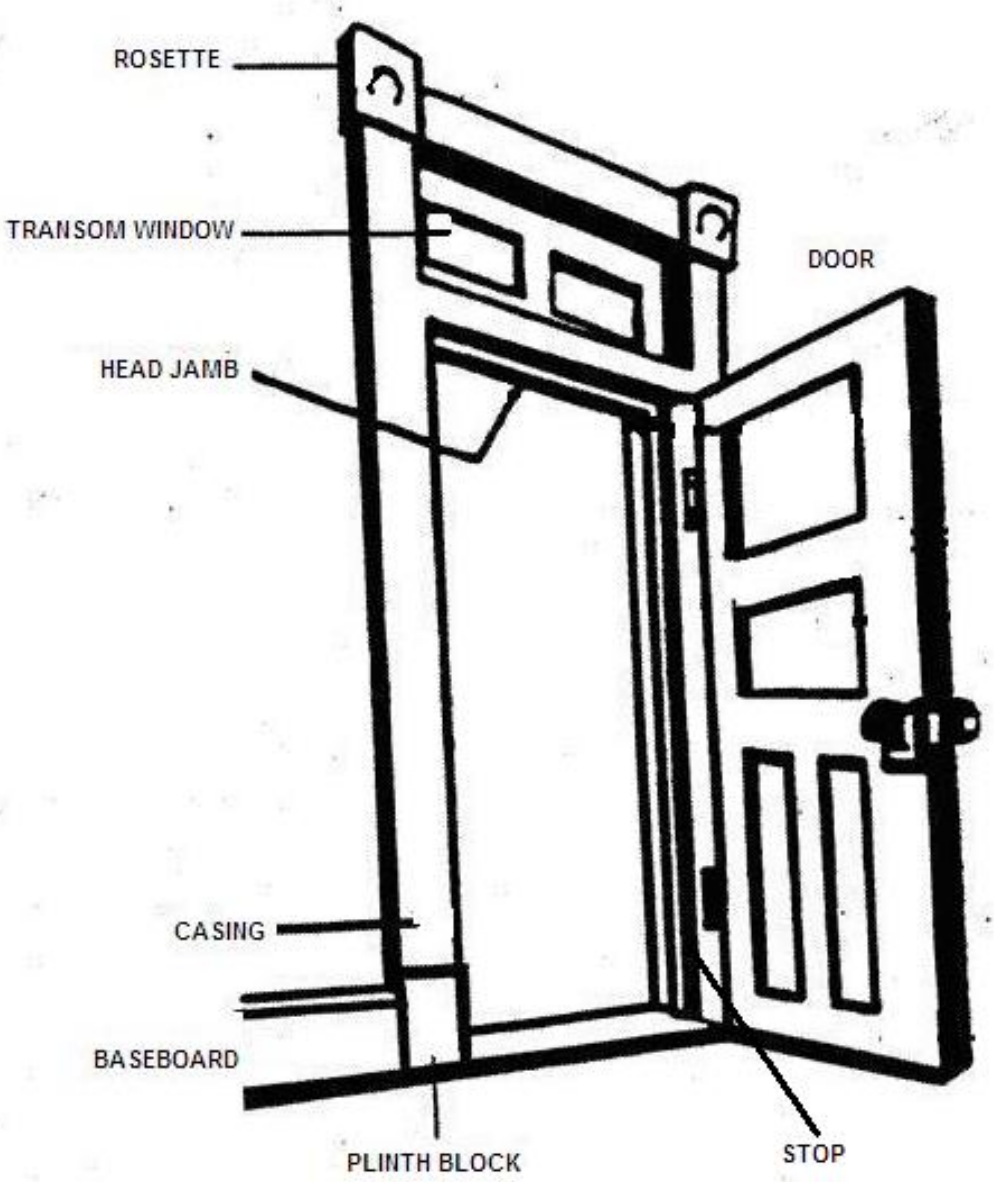
WALL COMPONENTS

STANDARD HOUSING COMPONENT TERMINOLOGY
(Continued)



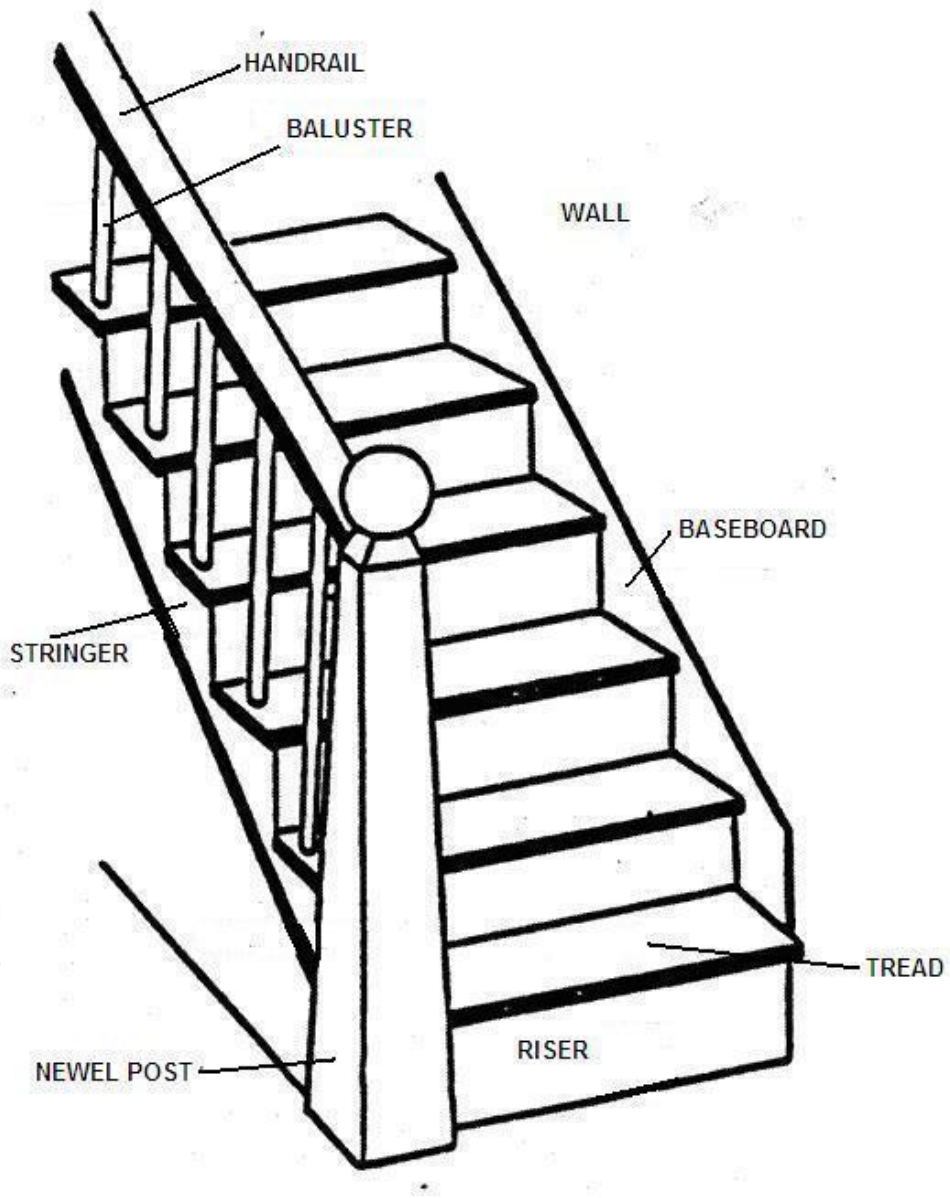
WINDOW COMPONENTS

STANDARD HOUSING COMPONENT TERMINOLOGY
(Continued)



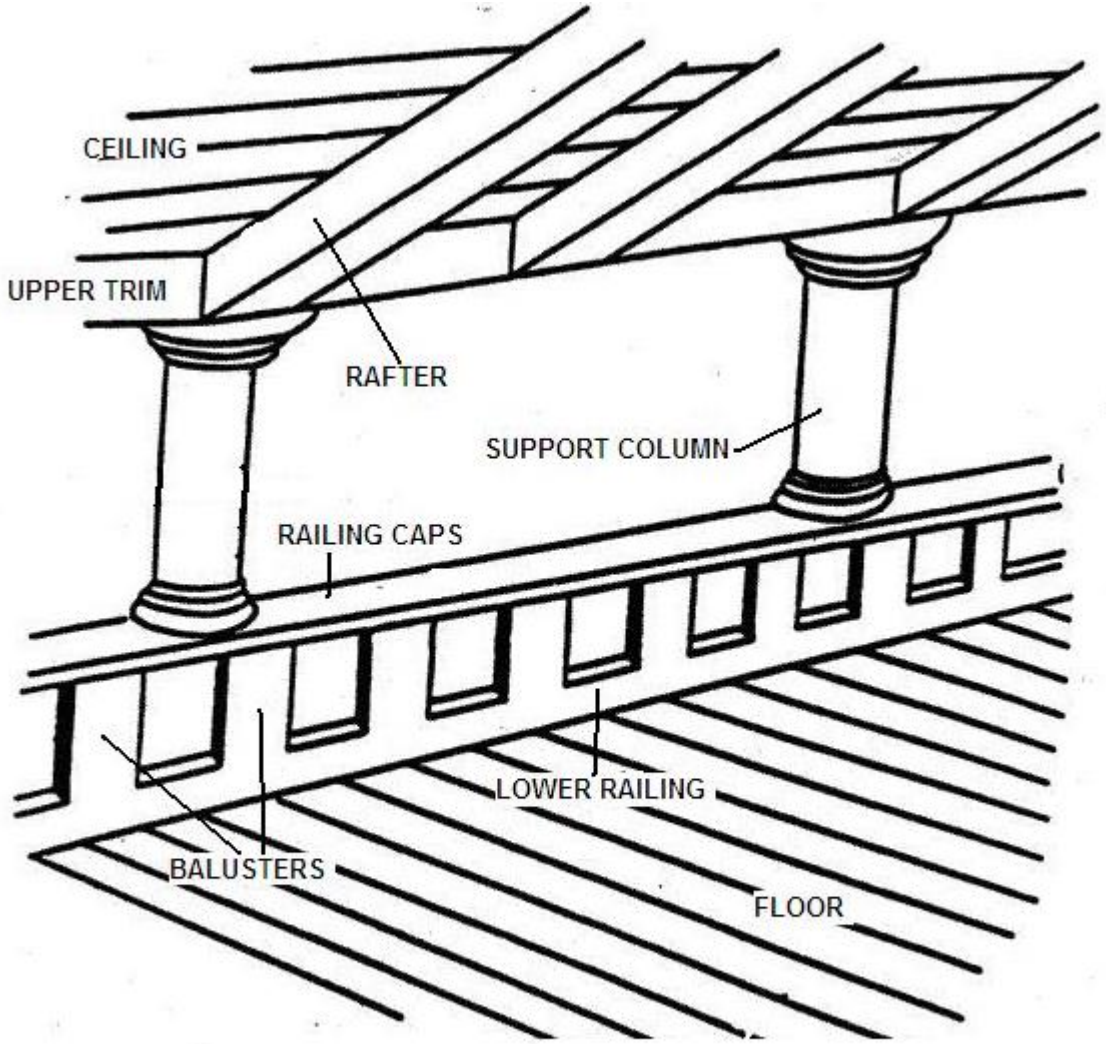
DOOR COMPONENTS

STANDARD HOUSING COMPONENT TERMINOLOGY
(Continued)



STAIRWAY COMPONENTS

STANDARD HOUSING COMPONENT TERMINOLOGY
(Continued)



PORCH COMPONENTS

APPENDIX D

New Jersey Department of Health
Child and Adolescent Health Program
PO Box 364
Trenton, NJ 08625-0364

PROTOCOL FOR DATA ENTRY IN THE CHILDHOOD LEAD INFORMATION DATABASE AND COMMUNICATION

- **Title**: Documentation of case management and environmental activity data in the Childhood Lead Information Database and communication with the New Jersey Department of Health (NJDOH).

- **Purpose:** To establish the protocols and standard operating procedures for the users of the Childhood Lead Information Database for:
  A. Documenting data; and
  B. Communicating with NJDOH about duplicate records.

- **Scope:** N.J.A.C. 8:51 Appendix D is applicable to all case managers, public health nurses, environmental inspectors, supervisors, and data entry personnel at the local health departments who access the Childhood Lead Information Database.

  - Protocol A: Documentation of data

1. Case management activity data and environmental activity data must be documented in the appropriate fields accurately and completely, within five working days from the time of data collection and/or activity.

2. Data entry may be performed either by the case managers/lead inspectors or by designated, trained data entry personnel.

3. Notes should only be used for the documentation of items pertaining to situations other than those that can be captured in the EVENTS, ASSESSMENTS, REFERRALS, SAMPLES, or ATTACHMENTS sections.

4. For every new item pertaining to any of the sections (for example, note, event, assessment, attachment, referral, samples) a new entry should be added (by clicking "***add new***") rather than appending the new entry to an existing entry.

- Protocol B: Communicating with NJDOH about duplicate records

When duplicate addresses and/or cases are observed, please send a message to your NJDOH contact person as described below:

1. The message for alerting NJDOH about duplicate patients must contain the following information:

    i. Patient identification number;
    ii. Which patient identification number is to be kept;
    iii. Patient Names (if different spellings, mention all);
    iv. Patient Date of Birth (DOB) (if different, mention all); and
    v. Correct name and DOB.

2. The message for alerting NJDOH about duplicate or incorrect addresses must contain the following information:

    i. All street addresses displayed;
    ii. Correct street address (if applicable);
    iii. ZIP code(s);
    iv. Correct ZIP code (if applicable); and
    v. Patient name and DOB.

APPENDIX E

New Jersey Department of Health
Child and Adolescent Health Program
PO Box 364
Trenton NJ 08625

USER CONFIDENTIALITY AGREEMENT

This Data Confidentiality Agreement (Agreement) is set forth in accordance with New Jersey and Federal statutes, regulations, procedures and policies. I understand that my access to personally identifiable data, information, and records (PII) as that term is defined in the Privacy Act of 1974 (Pub. L. 93-570, 88 Stat. 1896, enacted December 31, 1974, 5 U.S.C. 552a and Office of Management and Budget Circular (M-07-16), and maintained in Childhood Lead Information Database, (referred to as "database"), is limited to the PII necessary to carry out my essential job responsibilities.

In accordance with N.J.A.C. 8:51, N.J.S.A. 26:2-137.6 and Executive Order No. 100 (Governor Corzine; April 29, 2008) NJDOH hereby authorizes certain individuals in the following categories to access the database for performance of official duties of State and local government in cases of elevated blood lead levels in children upon signing of this Agreement:

1) case managers;
2) environmental inspectors;
3) supervisors responsible for overseeing or handling referrals and cases; and
4) support staff who need to have access to the database in order to support individuals set forth in 1-3 above.

By my signature below, I affirm that I have been advised of, understand, and agree to the following terms and conditions of my access to the database.

1. I will keep strictly confidential all information and PII, in any format, that I receive from the database or to which I have access in the database.

2. I will use my authorized access to the database in the performance of only my essential work functions, of State or local government official childhood elevated blood lead level referrals or case management duties, and limited to only my jurisdiction and user role.

3. I will comply with all controls established by NJDOH regarding the use of PII maintained within database.

4. I will not disclose PII or information in the database to unauthorized persons without written authorization of the PII owner, except as permitted under applicable State or Federal law. I understand and agree that my duty to avoid such disclosure will continue even after I am no longer employed.

5. I will not divulge, disclose, use, transfer, remove, or otherwise furnish PII or information from the database to any individual or organization for any use not authorized by NJDOH or to any person or entity not conducting official childhood elevated blood lead level referrals or case management duties, except as authorized by State law or rule or by Federal law or regulation.

6. I will exercise care to protect PII against accidental or unauthorized access, modifications, disclosures, or destruction.

7. I will not make any copies of PII or information in the database.

8. When discussing PII with other employees in the course of my work, I will exercise care to keep the conversation private so as not to be overheard by others who are not authorized to have access to PII.

9. I will not access or use any PII or information from database for any purpose that is not set forth with specificity in my essential childhood elevated blood lead level referrals or case management job functions without the written approval of my supervisor.

10. I agree to maintain the physical safeguards listed below for all paper copies of applications, reports, results, investigations, e-mails, facsimiles, etc., containing PII that I access in the database.

    a. Before stepping away from my desk, I will place all such documents in a folder;

    b. At the end of each work day, I will file and store all such documents in a locked filing cabinet; and

    c. I will not remove any such documents from my work place without prior written approval from my supervisors.

11. I will not leave any work related documents or information, in any format, paper of electronic or other, unattended at any time, including I will not leave work related documents or information unattended in my car at any time.

12. I will store all work documents and data extracts from the database only on secure network drives and devices.

    a. I will not store any PII on local hard drives or on non-secure network drives under any circumstances.

    b. I will not transfer any PII maintained on database to my laptop, USB key, or any other removable media (collectively known as a “Device”).

13. I will never use PII in an unencrypted e-mail communication for any reason.

14. I will always log out of any electronic database that I am using at the completion of my work. For added safety, I will close the browser window.

15. I will never share my password with anyone. I understand that each individual authorized to access the database must be assigned his/her own user-ID and password.

16. I will not store user-IDs or passwords on computers. I will disable any utility for storing user-IDs and passwords on the computer and will request authorized IT staff assistance if needed.

17. I understand that NJDOH may audit any record, electronic or written, that is part of or derived from the database or pertains to the information entered into the database.

18. I will report immediately to my supervisor and NJDOH any breach of confidentiality.

19. I understand that my failure to abide by this Agreement may result in suspension or termination of my user privileges, disciplinary action, and the imposition of any penalties as prescribed by State or Federal law.

Acknowledgement and Agreement

I have read the above User Confidentiality Agreement. I understand the content and intent of this Agreement and agree to abide by it.

_____
Printed Name and Title

_____ _____
Signature Date

APPENDIX F

New Jersey Department of Health
Child and Adolescent Health Program
PO Box 364
Trenton, NJ 08625-0364

NOTICE OF VIOLATION
INSTRUCTIONS FOR THE LOCAL BOARDS OF HEALTH

1. At a minimum, the notice of violation given to the property owner or the family of the child with an elevated blood lead level shall contain all the information provided in Appendix F.

2. No child specific information shall be mentioned on the notice of violation or on any other correspondence with the property owner.

TEMPLATE FOR NOTICE OF VIOLATION

Date

Name of Owner of Record
Address of Owner of Record

Subject: *(Fill in full address of subject property including apartment number if any.)*

Dear Owner:

In accordance with N.J.A.C. 8:51, an environmental intervention was conducted on _____ *(date of onsite testing)* at the above referenced property by _____ *(name of inspector)*. Testing of building components, household dust and/or bare soil was performed to determine if lead-based paint, lead dust or lead soil hazards exist.

We have found hazardous levels of lead at the location(s) identified in the attached report.

You are hereby required to remediate all lead hazards identified in the attached report within _____ days of the date of this notice. Failure to remediate all lead hazards within that timeframe will result in the initiation of legal proceedings against you and the levying of fines as set forth at N.J.A.C. 8:51-9.1.

N.J.A.C. 8:51-6.2 does allow interim control measures to be used to remediate exterior lead hazards; however, all interior lead hazards shall be treated using abatement methods. Please review the attached report to determine if you can use interim controls on the exterior hazards found at your property. If interim controls on exterior hazards are permitted, you must use qualified contractors trained in lead-safe work practices to perform the work. The contractors must comply with the provisions of N.J.A.C. 8:51-6.2, a copy of which is attached.

All lead abatement work undertaken in response to this Notice of Violation shall be performed in accordance with N.J.A.C. 5:17 Lead Hazard Evaluation and Abatement Code including, but not limited to:

- hiring a properly certified lead abatement firm to perform the abatement work;
- filing a permit prior to commencement of lead abatement work with the Local Construction Official;
- filing a 10-day notice with the Department of Community Affairs (DCA) prior to commencement of work;
- relocation of occupants and their belongings during performance of abatement work;
- hiring of an independent lead evaluation firm to conduct final clearance testing at the completion of lead abatement work; and
- filing for a Certificate of Clearance with the Local Construction Official to close out the permit.

All remediation work undertaken in response to this Notice of Violation shall comply with the owner's responsibilities and compliance criteria in accordance with N.J.A.C. 8:51-7.1(a)3:

- Within 30 days from the date of Notice of Violation identifying the lead hazards a scope of work shall be submitted to the local board of health.
- Within 45 days from the date of Notice of Violation identifying the lead hazards the property owner shall secure financial resources.
- Clearance testing shall be performed by an independent certified risk assessor no sooner than one hour after the final cleaning is completed pursuant to N.J.A.C. 5:17 and within 30 calendar days from the final cleaning pursuant to N.J.A.C. 8:51-8.2(a).

To locate a certified lead abatement firm or lead evaluation firm visit the DCA website at: http://www.state.nj.us/dca/codes/code_services/xls/clc.shtml.

Upon completion of work, the lead evaluation firm you selected to perform Clearance must provide you with a maintenance plan which provides for routine inspection of leaded surfaces which were not treated under this Notice of Violation to insure the paint remains intact as well as leaded surfaces which were treated using limited paint removal, enclosure or encapsulation methods to insure those treatments have not failed. All housing conditions which could contribute to the deterioration of lead-based paint such as leaking roofs or plumbing must also be routinely evaluated and deficiencies must be corrected.

The Federal Residential Lead-Based Paint Hazard Reduction Act, 42 U.S.C. 4852d, requires sellers and landlords of residential housing built before 1978 to disclose all available records and reports concerning lead-based paint and/or lead-based paint hazards, including the test results contained in this notice, to purchasers and tenants at the time of sale or lease, or upon lease renewal. Specific exceptions to this disclosure requirement are listed at 24 CFR Part 35.82. This disclosure must occur even if hazard reduction or abatement has been completed. Failure to disclose these test results is a violation of the U.S. Department of Housing and Urban Development, and the U.S. Environmental Protection Agency regulations at 24 CFR Part 35, and 40 CFR Part 745, and can result in a fine of up to $11,000 per violation.

If you have any questions, please contact _____ *(contact name)* at _____ *(phone number)*.

APPENDIX G

CHILDHOOD LEAD EXPOSURE PREVENTION HOME VISIT

Note: *This form is intended for use during nurse case manager home visits to document issues not captured through the Lead Hazard Assessment Questionnaire (Appendix A) or Preliminary Environmental Evaluation (Appendix L) as indicated. The nurse case manager and environmental inspector should collaborate in administration of the forms.*

Contact Information (To facilitate data entry, verify spellings against written documents.)			
Date of Visit	Child's Date of Birth		
Last (Family) Name of EBLL Child			
First Name	Middle Name		
Street Address		Apt. #	Floor #
Town/City		Zip Code	
Primary Phone **( )**	Alternate Phone or Cell **( )**		
Most likely times to reach someone at the primary phone			
Directions to Home			
Caregiver Information			
Person Interviewed			
Primary Language of the Household		Will translator be needed for future visits? ☐ Yes ☐ No	

Name/Relationship/Country of Origin	**Phone Numbers**	**Occupation and Work Schedule**
Mother	Home	Occupation
	Business	Work Schedule
Country of Origin	Cell	
Father	Home	Occupation
	Business	Work Schedule
Country of Origin	Cell	
Foster Parent/Guardian	Home	Occupation
	Business	Work Schedule
Country of Origin	Cell	
Other	Home	Occupation
	Business	Work Schedule
Country of Origin	Cell	

CHILDHOOD LEAD EXPOSURE PREVENTION HOME VISIT
(Continued)

Emergency Contact (who will always know how to reach you in case you move)		
Name	Relationship	Home Phone
Address		Cell Phone
Name	Relationship	Home Phone
Address		Cell Phone

Household Members

First Name	Last (Family) Name	Relationship	Sex	DOB	Health Status (i.e., pregnant, physical disability)	Date Screened for Lead (Child or pregnant woman only)

Medical Insurance/Social Services Currently Received By Child with Elevated Blood Lead Level

Family Care/Medicaid:	ID #: Medicaid #:
HMO:	Name:
HMO Case Manager:	
Uninsured:	Describe why:
Private Insurance:	Name:

Who is the child's current primary care provider?

Primary Care Provider/Clinic Name: _____ Phone #: _____

Address: _____

Is this child experiencing any barriers to obtaining medical care?

☐ Yes ☐ No

If Yes, specify:

☐ Transportation ☐ Language Barrier ☐ Not Convenient for Work Schedule

☐ Cannot Find Child Care for Other Children ☐ Literacy

☐ Other: _____

Does the family use any alternative sources for medical advice?

☐ Yes ☐ No

If Yes, specify:

Alternative Medical Provider: _____ Phone #: _____

Address: _____

CHILDHOOD LEAD EXPOSURE PREVENTION HOME VISIT
(Continued)

Special Child Services

Is the child being served by any of the following agencies?

WIC	☐ Yes	☐ No
Food Banks	☐ Yes	☐ No
Special Child Health Services	☐ Yes	☐ No
Early Intervention Services (EIS)	☐ Yes	☐ No
Head Start	☐ Yes	☐ No
Energy Assistance for Low Income Families	☐ Yes	☐ No
Department of Children and Families	☐ Yes	☐ No
Other Health Department Maternal and Child Health Programs *(describe)*:		
_____	☐ Yes	☐ No
_____	☐ Yes	☐ No

Child's Health History

Do you have any concerns about your child's health?

☐ Yes ☐ No

If Yes, explain: _____

_____

When was the last time your child was seen by a primary care provider? _____

Child's Lead Test History

Is the primary care provider aware of your child's blood lead test history?	☐ Yes	☐ No
Has your child ever been hospitalized for elevated blood lead levels?	☐ Yes	☐ No
If Yes, dates: _____		
Has your child ever received chelation therapy?	☐ Yes	☐ No
If Yes, dates: _____		
Has any other child in this household been diagnosed with elevated blood lead levels?	☐ Yes	☐ No
If Yes, name/dates: _____		
_____		

Other Health Conditions

Does your child have a history of.....? *(Check all that apply)*

Condition			**Date Diagnosed**
Iron Deficiency Anemia	☐ Yes	☐ No	_____
Hearing or Vision Problems, Headaches	☐ Yes	☐ No	_____
Attention Deficit or Learning Disabilities	☐ Yes	☐ No	_____
Weight Loss, Loss of Appetite	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____

CHILDHOOD LEAD EXPOSURE PREVENTION HOME VISIT
(Continued)

Other Health Conditions, Continued

Does your child have a history of.....? *(Check all that apply)*

Condition			Date Diagnosed
Heart Disease	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	
Mental Illness	☐ Yes	☐ No	
Sickle Cell	☐ Yes	☐ No	
Fine motor coordination, gait or balance problems	☐ Yes	☐ No	
Chronic constipation, vomiting or stomach pain	☐ Yes	☐ No	
Lethargy, tiredness, sleep loss	☐ Yes	☐ No	
Seizure Disorder	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Drug or alcohol dependency	☐ Yes	☐ No	
HIV	☐ Yes	☐ No	
Scoliosis	☐ Yes	☐ No	
Other: _____	☐ Yes	☐ No	
Other: _____	☐ Yes	☐ No	

Allergies

Allergies *(Check all that apply)*:

☐ Medications ☐ Food ☐ Environmental ☐ Other ☐None

If checked, describe: _____

Current Medications - Include all prescription medications, over-the-counter, and vitamin/mineral/herbal supplements (including supplements prescribed by a primary care provider).

Medication Prescribed by Primary Care Provider	Dose	Route	Frequency	Start Date	Reason
Over the Counter	**Dose**	**Route**	**Frequency**	**Start Date**	**Reason**
Vitamin/Mineral/Herbal Supplements/Home Remedies	**Dose**	**Route**	**Frequency**	**Start Date**	**Reason**

CHILDHOOD LEAD EXPOSURE PREVENTION HOME VISIT
(Continued)

Nutritional Assessment

Do you have food available for the family all days of the month? ☐ Yes ☐ No

Does your child have a good appetite? ☐ Yes ☐ No

How many meals does your child eat each day? _____

How many snacks? _____

Does your child eat at school/daycare? ☐ Yes ☐ No

How many meals? _____

Does your child eat at fast food restaurants? ☐ Yes ☐ No

How often? _____

Record the frequency with which the child eats the following foods:	Daily	Weekly	Never
Milk Products:			
Cheese, Yogurt			
Whole Milk			
Skim or Low-fat Milk			
Breast Milk			
Formula			
Meat and Beans:			
Chicken, Beef, Pork, Poultry			
Fish and Shellfish			
Eggs			
Dried Beans, Peas, Peanut Butter			
Grains:			
Bread, Crackers, Cereal, Macaroni, Spaghetti, Tortillas, Pasta			
Fruits:			
Fruit, Fruit Juice			
Vegetables:			
Vegetables			
Potatoes			
Other:			
Soft Drinks			
Pastries, Ice Cream, Desserts			
Candy			
Chips, Snacks or Other High-fat Foods			

CHILDHOOD LEAD EXPOSURE PREVENTION HOME VISIT
(Continued)

Home Safety Checklist					
Working smoke alarms	☐ Yes	☐ No	Living area free of dust and debris	☐ Yes	☐ No
Medications stored out of reach	☐ Yes	☐ No	Insects/rodents absent	☐ Yes	☐ No
Structurally sound	☐ Yes	☐ No	Absence of foul odor	☐ Yes	☐ No
Adequate heat	☐ Yes	☐ No	Adequate water supply	☐ Yes	☐ No
Stairs in good repair	☐ Yes	☐ No	Adequate sewage disposal	☐ Yes	☐ No
Child safety gates present	☐ Yes	☐ No	Uses child seat in car	☐ Yes	☐ No
Unobstructed exits/entries	☐ Yes	☐ No	Emergency numbers present	☐ Yes	☐ No
Uncluttered living space	☐ Yes	☐ No	Adequate lighting in hall/stairs/exit	☐ Yes	☐ No
Mats/throw rugs secured	☐ Yes	☐ No	Locked storage of toxic chemicals	☐ Yes	☐ No
Proper functioning stove	☐ Yes	☐ No	Night lights in bathrooms	☐ Yes	☐ No
Functioning refrigerator	☐ Yes	☐ No	Covers on electrical outlet	☐ Yes	☐ No
Sink with running water	☐ Yes	☐ No	Family escape plan for fire	☐ Yes	☐ No
Properly vented gas appliances	☐ Yes	☐ No	Fire extinguishers present and working	☐ Yes	☐ No
No exposed/frayed wiring	☐ Yes	☐ No	Working carbon monoxide detector	☐ Yes	☐ No
Water temp. set <120F	☐ Yes	☐ No	Yard free of clutter	☐ Yes	☐ No
Window guards present (if unit is above ground floor)	☐ Yes	☐ No	Curtain/blind cords secured	☐ Yes	☐ No
			Trash in covered receptacle	☐ Yes	☐ No
No mold/moisture	☐ Yes	☐ No			
			Absence of tobacco smoke in unit	☐ Yes	☐ No
Allergen-proof mattress/pillow covers on beds of asthmatics	☐ Yes	☐ No	Heavy furniture and electronics secured	☐ Yes	☐ No

Name of Case Manager who completed this form:	
Name (Print)	Date

Name of Case Manager who updated this form since initial home visit:	
Name (Print)	Date

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

APPENDIX I

New Jersey Department of Health
Child and Adolescent Health Program
PO Box 364
Trenton, NJ 08625-0364

NUTRITIONAL ASSESSMENT

(to be used at subsequent home visits)

Name of Baby/Child	Age

Nutritional Assessment

Do you have food available for the family all days of the month? ☐ Yes ☐ No

Does your child have a good appetite? ☐ Yes ☐ No

How many meals does your child eat each day? _____

How many snacks? _____

Does your child eat at school/daycare? ☐ Yes ☐ No

How many meals? _____

Does your child eat at fast food restaurants? ☐ Yes ☐ No

How often? _____

Record the frequency with which the child eats the following foods:	Daily	Weekly	Never
Milk Products:			
Cheese, Yogurt			
Whole Milk			
Skim or Low-fat Milk			
Breast Milk			
Formula			
Meat and Beans:			
Chicken, Beef, Pork, Poultry			
Fish and Shellfish			
Eggs			
Dried Beans, Peas, Peanut Butter			
Grains:			
Bread, Crackers, Cereal, Macaroni, Spaghetti, Tortillas, Pasta			
Fruits:			
Fruit, Fruit Juice			
Vegetables:			
Vegetables			
Potatoes			
Other:			
Soft Drinks			
Pastries, Ice Cream, Desserts			
Candy			
Chips, Snacks or Other High-fat Foods			

APPENDIX J

New Jersey Department of Health
Child and Adolescent Health Program
PO Box 364
Trenton, NJ 08625-0364

QUALITY ASSURANCE AND IMPROVEMENT

Purposes:

- To assure the accuracy of data entry into the Childhood Lead Information Database;
- To provide and educate the staff related to the quality of data being placed into the Childhood Lead Information Database; and
- To provide feedback to the Department of Health on Quality Improvement issues related to the outcome of the Quality Assurance Audit.

Guidelines for Reporting of Quality Assurance and Improvement

- Complete the Quality Assurance and Improvement Audit and submit to NJDOH quarterly in the format designated by the NJDOH Child Health Coordinator by the 15th of the following months: January, April, July and October.
- Health Officer or designee shall perform the quality assurance audit on 10% of active case management cases. (Minimum of five cases and maximum of 20 cases shall be reviewed). This audit will include both nursing case management and environmental inspector cases.

Name of Health Department	Quarterly Review Date
Reviewer Name	

LeadTrax ID #	Name of Nurse Case Manager	Name of Environmental Inspector	Name of Data Entry Clerk	QA/QI

APPENDIX K

CHILDHOOD LEAD EXPOSURE
CASE CLOSURE

Child's Full Legal Name	
Address	
Date Case Closed	Last Blood Lead Level (BLL) _____ µg/dL ___capillary ___venous
Name of Primary Care Provider (notified of case closure)	Date Case Closure Form sent to Primary Care Provider

CRITERIA FOR CASE CLOSURE		
Cases should be closed when the following criteria are met: 1. Single, capillary, BLL 5 µg/dL or greater, in accordance with 2.4(a)-(b). 2. Single, venous, BLL 5 to 9 µg/dL, in accordance with 2.4(c) and 4.1 (g)-(h). 3. Two, venous (1-4 months apart), BLL 5 to 9 µg/dL, in accordance with 2.4(c) and 4.1(a)-(d), and as applicable 4.1(f), 4.2, 4.3(a)-(b), 4.3(c). 4. Single, venous, BLL 10 to 44 µg/dL, in accordance with 2.4(c) and 4.1(a)-(d), and as applicable 4.1(f), 4.2, 4.3(a)-(b), 4.3(c). 5. Single, venous, BLL 45 µg/dL or greater, in accordance with 2.4(d) and 4.1(a)-(d), and as applicable 4.1(f), 4.2, 4.3(a)-(b), 4.3(c).	**OR**	**Cases should be closed administratively if:** • At least 3 documented attempts to locate or gain access to the child and parent/legal guardian have failed. • One documented attempt as certified letter from the board of health to the parent/legal guardian has failed.

CHECK ALL THAT APPLY:		
Check	**Closure Reasons**	**Additional Notes:**
	Single venous BLL below 5µg/dL after 3 months.	
	Environmental lead hazards have been abated and/or managed using interim controls.	
	Plans have been completed with the primary care provider and the parent/legal guardian for long-term developmental follow-up.	
	Administrative Closure: Lost to follow-up/Unable to locate	Date of first home visit attempt: _____ Date of second home visit attempt: _____ Date certified letter sent: _____
	Services refused	
	Moved out of Jurisdiction/State to: _____ _____	Date of referral: _____ Name of Agency referred to: _____
	Other (Specify): _____ _____	

Signature of Case Manager	Date of Signature

LP-11
APR 16

APPENDIX L

New Jersey Department of Health
Child and Adolescent Health Program
PO Box 364
Trenton, NJ 08625-0364

PRELIMINARY ENVIRONMENTAL EVALUATION

	Total Number
1. Including yourself, what is the number of people living in the home?	
a. Children less than 72 months of age (before the 6th birthday)	
b. Pregnant women	

2. In your current home, do you:

☐ Own ☐ Rent ☐ Alternate Occupancy Arrangement

3. Describe your current home:

☐ Single family detached ☐ Duplex ☐ Multi-family housing (apartment, condo, townhome) ☐ Other

4. Was your home built before 1978?

☐ Yes ☐ No ☐ Don't Know ☐ Reported by Tenant ☐ Confirmed by Home Visitor

5. Do you have any of the following conditions in your home?	*Please mark applicable responses with a "X".*			
	Reported	Observed	None	No Access
a. Chipped or peeling paint	☐	☐	☐	☐
b. Old pipes	☐	☐	☐	☐

6. Has your home been tested for?	*Please mark applicable responses with a "X".*				
	Tested and Passed	Tested and Failed but Abatement Complete	Tested and Failed but Abatement Not Complete	Not Tested	Don't Know
a. Lead	☐	☐	☐	☐	☐

7. In the past 30 days, have you seen evidence of leaks from the ceilings in your home? *(Check all that apply)*	*Please mark applicable responses with a "X".*		
	Reported	Observed	None
a. Leaks from ceilings?	☐	☐	☐

8. What kind of floors do you have in your home?	*Please mark applicable responses with a "X".*			
	Hard Surface (Tile, Wood, Laminate)	Area Rug(s)	Carpet	N/A
a. Kitchen	☐	☐	☐	☐
b. Bathroom(s)	☐	☐	☐	☐
c. Bedroom(s)	☐	☐	☐	☐
d. Living Room	☐	☐	☐	☐
e. Dining Room	☐	☐	☐	☐
f. Other	☐	☐	☐	☐

9. How often do you clean the floors in your home with the following methods?	*Please mark applicable responses with a "X".*			
	Always	Frequently	Rarely	Never
a. Vacuum	☐	☐	☐	☐
b. Sweep	☐	☐	☐	☐
c. Wet Mop	☐	☐	☐	☐

PRELIMINARY ENVIRONMENTAL EVALUATION
(Continued)

10. Since you have lived here, has there been any active remodeling in your home/this unit in the past year, or do you know of any future plans for remodeling in your home within the next year?	*Please mark applicable responses with a "X".*		
	Yes	No	Don't Know
a. Past remodel	☐	☐	☐
b. Future remodel	☐	☐	☐

11. If chipping and peeling paint was observed in the following rooms *(see Question 5)*, note the following:	Paint Condition (fair, poor) and Extent (visible chips and/or dust in window wells, window sills, on the floor)	Specific Location Within the Room
a. Entrance to residence		
b. Hallway(s)		
c. Living Room		
d. Bedroom(s)		
e. Bathroom(s)		

12. What is the primary source of water in your home?

☐ Municipal ☐ Private Well ☐ Don't Know

12a. To your knowledge, has the water ever been tested for lead?

☐ Yes ☐ No ☐ Don't Know

13. Is there bare soil to which children have access?

☐ Yes ☐ No ☐ Don't Know

14. Is this dwelling located near a lead-producing industry (e.g. battery plant, smelter, radiator repair shop, electronics/soldering industry)?

☐ Yes ☐ No ☐ Don't Know

14a. If Yes, specify the industry and location (if known):

15. Is the dwelling located within two blocks of a major highway, freeway, elevated highway, or other transportation structures?

☐ Yes ☐ No

16. To your knowledge, does anyone in the household: *(Check all that apply.)*	*Please mark applicable responses with a "X".*	
	Yes	No
a. Work in an occupation or hobby that uses lead	☐	☐
b. Use imported cosmetics	☐	☐
c. Use cultural remedies	☐	☐
d. Prepare, serve, and/or store liquids/foods in metal, pewter, glazed, soldered or crystal containers	☐	☐
e. Use imported spices	☐	☐
f. Consume snacks or candies with chili, tamarind, or sold in clay pots	☐	☐

Appendix M Summary of Public Health Actions for Elevated Blood Lead Levels			
Category 1			
Blood Lead Level	**Specimen Type and Frequency**	**Case Management**	**Environmental Intervention or Preliminary Environmental Evaluation**
5 to 9 ug/dL	Single capillary	**2.4(a)-(b) Activities** **2.5 Home Visit Schedule** • Home visit • Provide education, both written and verbal, and counseling about the effects of elevated blood lead levels and its prevention (nutrition, personal hygiene, housekeeping) and other risk reduction measures. • Recommend venous blood lead retesting of the child and blood lead screening of siblings, other children, and pregnant women living in the same household. • Determine whether or not the child has a primary care provider. • Refer to appropriate community resources.	N/A

Category 2			
Blood Lead Level	**Specimen Type and Frequency**	**Case Management**	**Environmental Intervention or Preliminary Environmental Evaluation**
5 to 9 ug/dL	Single venous	**2.4(c) Activities** **2.5 Home Visit Schedule** • Home visit • Provide education, both written and verbal, and counseling about the effects of elevated blood lead levels and its prevention (nutrition, personal hygiene, housekeeping) and other risk reduction measures. • Determine whether or not the child has a primary care provider. Refer to appropriate community resources. • Complete case management assessments (Appendices G, H, I) • Review the Preliminary Environmental Evaluation (Appendix L) to ensure that the child's environment has been evaluated for potential paint and non-paint lead hazards. • Assist the family in arranging for venous follow-up and monitor blood lead retesting and results. • Educate about lead hazards that may be present on the premises. • Monitor follow-up activities.	**4.1(g)-(h) Activities** **2.5 Home Visit Schedule** Conduct Preliminary Environmental Evaluation (Appendix L)

Category 3			
Blood Lead Level	**Specimen Type and Frequency**	**Case Management**	**Environmental Intervention or Preliminary Environmental Evaluation**
5 to 9 ug/dL OR 10 to 44 ug/dL	Two venous (1-4 months apart) Single venous	**2.4(c) Activities** **2.5 Home Visit Schedule** • Home visit • Provide education, both written and verbal, and counseling about the effects of elevated blood lead levels and its prevention (nutrition, personal hygiene, housekeeping) and other risk reduction measures. • Determine whether or not the child has a primary care provider. • Refer to appropriate community resources. • Complete case management assessments (Appendices G, H, I) • Assist the family in arranging for venous follow-up and monitor blood lead retesting and results. • Educate about lead hazards that may be present on the premises. • Monitor follow-up activities. • Assess the need for emergency relocation. • Ensure a hazard assessment is completed at all proposed relocation addresses.	**4.1 (a)-(d) Activities** **4.1 (e) Home Visit Schedule** Conduct Environmental Intervention **4.1 (f) (premise constructed in 1978 or later)** • Hazard Assessment Questionnaire (Appendix A) at primary residence. **4.2 (children up to 72 months)** • Hazard Assessment at primary residence. • Limited Hazard Assessment at previous primary and secondary addresses. **4.3(a) & (b) (children 72 months or greater)** • Limited Hazard Assessment at primary and secondary addresses. **4.3(c) (children 72 months or greater who have been medically diagnosed as having a development disability or developmental delay in which the effective developmental age is up to 72 months)** • Hazard Assessment at primary residence. • Limited Hazard Assessment at previous primary and secondary addresses.

Category 4			
Blood Lead Level	**Specimen Type and Frequency**	**Case Management**	**Environmental Intervention or Preliminary Environmental Evaluation**
45 or greater ug/dL	Single venous	**2.4(d) Activities** **2.5 Home Visit Schedule** • Home visit • Provide education, both written and verbal, and counseling about the effects of elevated blood lead levels and its prevention (nutrition, personal hygiene, housekeeping) and other risk reduction measures. • Determine whether or not the child has a primary care provider. • Refer to appropriate community resources. • Complete case management assessments (Appendices G, H, I) • Assist the family in arranging for venous follow-up and monitor blood lead retesting and results. • Educate about lead hazards that may be present on the premises. • Monitor follow-up activities. • Assess the need for emergency relocation. • Ensure a hazard assessment is completed at all proposed relocation addresses. • Recommend to the primary care provider immediate hospitalization. • Recommend to the primary care provider to communicate with New Jersey Poison Information and Education System (NJPIES). • Ensure that the child is relocated to lead-safe housing. • Ensure that the environmental intervention is completed at the relocation address prior to hospital discharge. • Assist the family in obtaining required prescriptions before	**4.1 (a)-(d) Activities** **4.1 (e) Home Visit Schedule** Conduct Environmental Intervention **4.1 (f) (premise constructed in 1978 or later)** • Hazard Assessment Questionnaire (Appendix A) at primary residence. **4.2 (children up to 72 months)** • Hazard Assessment at primary residence. • Limited Hazard Assessment at previous primary and secondary addresses. **4.3(a) & (b) (children 72 months or greater)** • Limited Hazard Assessment at primary and secondary addresses. **4.3(c) (children 72 months or greater who have been medically diagnosed as having a development disability or developmental delay in which the effective developmental age is up to 72 months)** • Hazard Assessment at primary residence. • Limited Hazard Assessment at previous primary and secondary addresses.

		discharge from the hospital. • Ensure proper administration of the medication and timely medical follow-up during and after chelation. • Maintain communication regarding child's response to chelation, neurodevelopmental assessments, the referral process and the abatement status of the primary residence.	

N.J.A.C. 8:51 Defined Terms

Case Management - a public health nurse's coordination, oversight and/or provision of the services required to identify lead sources, eliminate a child's lead exposure and reduce the child's blood lead level below 5 µg/dL.

Case Management Assessments - assessments that identify the wellness of the child and family consisting of Appendices G, H, and I.

Preliminary Environmental Evaluation - collection of background information on housing physical characteristics using Appendix L.

Environmental Intervention – identification of lead hazards in the child's environment, order of abatement or interim controls, education of the family.

Hazard Assessment –

- Administer the Hazard Assessment Questionnaire (Appendix A) and complete Appendices B and F.
- Collect information regarding physical characteristics and residential use patterns including age of structure and any additions; copies of any previous lead hazard inspections; diagram of the dwelling showing each room and its use; number of children up to 72 months of age and pregnant women; potential lead exposure sources in the neighborhood.
- Conduct a visual inspection of all interior and exterior painted surfaces and for evidence of chewing on painted surfaces.
- Test defective paint on interior surfaces, other buildings on the premises, furniture, toys and play structures using an XRF instrument.
- Test paint on intact friction surfaces and on chewable or evidence of chewing surfaces using an XRF instrument.
- Test paint on impact surfaces if damage of damage using an XRF instrument.
- Dust sampling of window sills and floors and areas where the child is likely to come in contact with dust.
- Evaluate exterior of the residence if no lead-based paint hazard is found in the interior.
- Testing of the soil, if no lead-based paint hazard is found in either the interior or exterior of the residence.

Limited Hazard Assessment –

- Administer the Hazard Assessment Questionnaire (Appendix A) and complete Appendices B and F.
- Collect information regarding physical characteristics and residential use patterns including age of structure and any additions; copies of any previous lead hazard inspections; diagram of the dwelling showing each room and its use; number of children up to 72 months of age and pregnant women; potential lead exposure sources in the neighborhood.
- Conduct a visual inspection of all interior and exterior painted surfaces and for evidence of chewing on painted surfaces.
- Test defective paint on interior surfaces, other buildings on the premises, furniture, toys and play structures using an XRF instrument.
- Dust sampling of window sills and floors and areas where the child is likely to come in contact with dust.

Lead Hazard - any condition that allows access or exposure to lead, in any form, to the extent that adverse human health effects are possible.

Note:

- Abatement is required on interior surfaces where a lead hazard has been identified.
- Abatement or interim controls may be ordered at the local health department's discretion on exterior surfaces where a lead hazard has been identified.