

Property Address: _____

HOME MODIFICATION SUSTAINABILITY SURVEY

 (Date of Survey)

NOTE: Obtain permission from resident to complete survey. Check box if "No"

	Yes	No
<input type="checkbox"/> DEHUMIDIFIER		
Do you still have it?	<input type="checkbox"/>	<input type="checkbox"/>
Have you used it in the last 3 months? If yes, when did you use it last? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you checked to make sure it is draining properly? OR Have you emptied the collection bucket?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> FURNACE FILTER		
Have you changed the furnace filter? If no, why not? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you need a new one?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> AIR CLEANER		
Do you still have it?	<input type="checkbox"/>	<input type="checkbox"/>
Have you used it in the last 3 months? If yes, when did you use it last? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you cleaned the filter?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PILLOW CASE COVER		
Is it still on the pillow?	<input type="checkbox"/>	<input type="checkbox"/>
Have you cared for it as recommended?	<input type="checkbox"/>	<input type="checkbox"/>
Is it still in good condition (no rips, holes, shredding)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> MATTRESS COVER		
Is it still on the bed?	<input type="checkbox"/>	<input type="checkbox"/>
Have you cared for it as recommended?	<input type="checkbox"/>	<input type="checkbox"/>
Is it still in good condition (no rips, holes, shredding)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> BOX SPRING COVER		
Is it still on the bed?	<input type="checkbox"/>	<input type="checkbox"/>
Have you cared for it as recommended?	<input type="checkbox"/>	<input type="checkbox"/>
Is it still in good condition (no rips, holes, shredding)?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
<input type="checkbox"/> VACUUM		
Do you still have it?	<input type="checkbox"/>	<input type="checkbox"/>
Does it still work?	<input type="checkbox"/>	<input type="checkbox"/>
Have you used it in the last 3 months? If yes, when did you use it last? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you changed the bag? If yes, were you able to purchase replacement bags? OR Have you emptied the dust collection bin? If yes, when did you empty it last? _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> SMOKE DETECTOR		
Is it still in place?	<input type="checkbox"/>	<input type="checkbox"/>
Have you tested it yet?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> CARBON MONOXIDE MONITOR		
Is it still in place?	<input type="checkbox"/>	<input type="checkbox"/>
Have you tested it yet? If yes, when did you test it? _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PLUMBING REPAIRS		
Have you noticed any more leaks?	<input type="checkbox"/>	<input type="checkbox"/>
Is the area around the repair dry?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> MOLD REMEDIATION		
Have you noticed any more mold growth?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a moldy odor in the house?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> WINDOW REPLACEMENT/REPAIR		
Does the window open and close properly?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any cracks or broken glass?	<input type="checkbox"/>	<input type="checkbox"/>
Is the screen in place?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PEST CONTROL		
Have you noticed any more problems?	<input type="checkbox"/>	<input type="checkbox"/>

RECOMMENDATIONS FOR OWNER/RESIDENT

	Yes	No
1.		
Was it completed?	<input type="checkbox"/>	<input type="checkbox"/>
?	<input type="checkbox"/>	<input type="checkbox"/>
2.		
Was it completed?	<input type="checkbox"/>	<input type="checkbox"/>
?	<input type="checkbox"/>	<input type="checkbox"/>
3.		
Was it completed?	<input type="checkbox"/>	<input type="checkbox"/>
?	<input type="checkbox"/>	<input type="checkbox"/>
4.		
Was it completed?	<input type="checkbox"/>	<input type="checkbox"/>
?	<input type="checkbox"/>	<input type="checkbox"/>
5.		
Was it completed?	<input type="checkbox"/>	<input type="checkbox"/>
?	<input type="checkbox"/>	<input type="checkbox"/>

RECOMMENDATIONS FOR LANDLORD

	Yes	No
1.		
Was it completed?	<input type="checkbox"/>	<input type="checkbox"/>
?	<input type="checkbox"/>	<input type="checkbox"/>
2.		
Was it completed?	<input type="checkbox"/>	<input type="checkbox"/>
?	<input type="checkbox"/>	<input type="checkbox"/>
3.		
Was it completed?	<input type="checkbox"/>	<input type="checkbox"/>
?	<input type="checkbox"/>	<input type="checkbox"/>
4.		
Was it completed?	<input type="checkbox"/>	<input type="checkbox"/>
?	<input type="checkbox"/>	<input type="checkbox"/>
5.		
Was it completed?	<input type="checkbox"/>	<input type="checkbox"/>
?	<input type="checkbox"/>	<input type="checkbox"/>

Symptom Survey

How often over the past 4 weeks has:

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a) Your child complained of being short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Exertion (such as running) made your child breathless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Your child coughed at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Your child been woken up by wheezing or coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Your child stayed indoors because of wheezing or coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Your child's education suffered due to his/her asthma (during school)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Your child's asthma interfered with his/her life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Asthma limited your child's activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Taking his/her inhaler or other treatments interrupted your child's life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) You had to made adjustments to family life because of your child's asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>