



**City of Sanford – Immediate Needs Pre-Application**

The City of Sanford’s Immediate Needs Program is designed to provide funds in the form of a grant to qualified applicants with necessary repairs and/or alterations to affect the immediate livability of the home.

The five (5) trades in which assistance can be provided are roofing, electrical, plumbing, HVAC (heating and cooling systems), and accessibility/barrier removal.

**At a minimum, the following criteria must be met in order to be determined eligible:**

- Applicant must be the unit’s owner by proof of a deed in their name;
- Home must be located within Sanford City Limits
- Occupying household must be at or below 80% of the median income level (see chart below);
- All mortgages, taxes, and special assessments on the home must be current and paid;
- Owner must occupy the property as their principal residence by proof of homestead exemption; and
- Home must have homeowner’s insurance or notification from insurance company of inability to insure due to state of home (insurance must be attained prior to project completion).

Pre-applications will be accepted from income-eligible households. Applications will be accepted between the hours of 8am – 4pm in the Seminole County Community Services Office at 534 West Lake Mary Boulevard; Sanford, Florida 32773. **Only fifty (50) applications will be accepted on a first-come, first accepted basis.** The pre-applications will be used to establish a waiting list for the City of Sanford Immediate Needs Program.

**Median Income Level**

<b>Household Size</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>
<b>Income Level</b>	\$32,800	\$37,450	\$42,150	\$46,800	\$50,550	\$54,300	\$58,050	\$61,800

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**Immediate Needs Pre-Application**  
*(Please print legibly in dark ink) (Revised 12/27/16)*

Head of Household	Phone #	Date of Birth	Age
Address	Apt. #	City Zip Code	Alternative Phone #
Co-Head of Household	Phone #	Date of Birth	Age

**Additional Members in Household**

*(If necessary, use additional paper for more household member names)*

Name(s) 1	Social Security #	Date of Birth	Age	Relationship
2				
3				
4				

**Gross Monthly Household Income**

*(Total Before Taxes)*

Employment \$	Social Security \$
Unemployment \$	SSI / SSD \$
Workers Comp \$	Public Assistance \$
Pension/Retirement \$	Life Insurance/Annuity \$
Child Support \$	Other \$
	<b>TOTAL \$</b>

All programs are open to all without regard to race, color, national origin, sex, handicap, familial status, or religion. Assistance is provided according to the availability of funding; some restrictions apply.

I certify that all information I have provided above is true and correct. I/we understand that Florida Statute 817 provides that willful false statements or misrepresentation concerning income; asset or liability information relating to financial condition is a misdemeanor of the first degree, punishable by fines and imprisonment provided under Statutes 775.082 or 775.083. I/we further understand that any willful misstatement of information will be grounds for disqualification. I/we certify that the application information provided is true and complete to the best of my/our knowledge. I/we consent to the disclosure of information for the purpose of income verification related to making a determination of my/our eligibility for program assistance. I/we agree to provide any documentation needed to assist in determining eligibility and are aware that all information and documents provided are a matter of public record. I/we further understand that if any misrepresentation or fraudulent statement is discovered after assistance has been provided the County will demand and pursue through all legal remedies available, repayment of the funds provided for the assistance that was provided.

Head of Household Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>COMMUNITY DEVELOPMENT USE ONLY:</b>
CUSTOMER SERVICE REPRESENTATIVE: _____
PROJECT COORDINATOR: _____
PROJECT MANAGER: _____
OUTCOME: _____

<b>TIME/DATE STAMPED:</b>