Rev. 2/17/2016

SEMINOLE COUNTY COMMUNITY ASSISTANCE
APPLICATION FOR ASSISTANCE

All sections of the application **must** be completed; if a section does not apply to your household, enter "N/A."

PLEASE CHECK ASSISTANCE APPLYING FOR

All documents listed on pages 7 through 10 that correspond with the assistance you are applying for must be enclosed with the application.

☐ TBRA

(Please Print Clearly)

	Applicant	Co-Applicant (Spouse or member 18 & older)
Full Name:		
Age & Date of Birth:		
Social Security #:		
Gender: Circle One	Male or Female	Male or Female

Relationship of Co-Applicant to Applicant: ☐ Spouse ☐ Partner ☐ Roommate ☐ Relative ☐ Non-relative

Ethnicity/Special Needs: **(For reporting purposes only, please check all that apply for Head of the Household Only)**

White ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ Native American ☐ Other ☐

Farm Worker ☐ Disabled ☐ or Disabled Minor ☐ Elderly ☐ Homeless ☐ Other________________________

Applicant Street & Mailing Address:

Street Address:	Rent ☐ Own ☐	State:
City:	City Limit ☐ Unincorporated ☐	Zip:
Mailing Address (if different):		State:
City:		Zip:

Telephone Number: ______________________________ **E-mail Address:** ____

Emergency Contact Name: ________________________________ **Emergency Phone Number:** ________________________

Marital Status: ☐ Married ☐Separated ☐Single ☐Divorced ☐Widowed

OTHER MEMBERS IN THE HOUSEHOLD

Name	Date of Birth	Age	Relationship to Applicant	Social Security Number

*If additional space to list household members is needed please attach information to the back of this application.

Applicant Employment Information:

Current/Last Employer Name:		Phone Number:
Address:		
Supervisor:		Fax Number:
Position:	Start Date:	End Date:

Co-Applicant Employment Information:

Current/Last Employer Name:		Phone Number:
Address:		
Supervisor:		Fax Number:
Position:	Start Date:	End Date:

*If additional space to list employment information is needed please attach information to the back of this application.

INCOME RECEIVED MONTHLY

List the amount of income received monthly in column two by the source of income listed in column one. If income is listed in column one then the documents listed in column three are required if applicable. Column three lists the required documents of the various income sources listed in column one. **Forms,** in bold, are available in the Community Assistance Office or online with the application. The Community Assistance Office can notarize required documents below.

Column One	**Column Two**	**Column Three** Client will also have the option to use **3rd Party Verification** if source is not available or more information is required to clarify income and assets. The client is responsible for any costs associated with the completion of **3rd Party Verifications.** ***The Deposit and Dental Programs require 3rd party verifications.***
Employment	**$**	**Provide Pay Stubs.** All adults (18 years of age or older) in the household who are currently claiming no income, must sign and notarize a **Verification of No Monthly Income** form
AFDC/TANF/ (Cash Assistance)	**$**	AFDC/TANF (Aid to Families with Dependent Children/Temporary Assistance for Needy Families) Printout or current decision letter from the Department of Children and Families. **Provide Decision Notice or Printout**
Social Security, SSI, SSDI, Pensions (VA, Military, Retirement)	**$**	Provide a copy of current year Award or Benefit Statement. *A statement is required for each household member receiving benefits.* **(Provide current year award letters)**
Unemployment Compensation	**$**	All adults (18 years of age or older) in the household who are currently receiving unemployment, must sign and have notarized a **DEO/AWI** (form).
Alimony/ Child Support	**$**	Divorce Decree or Court Order and child support and/or a*limony payment schedule if applicable,* (*must show Child Support)*; **or** Provide a notarized letter from the person paying support; *only if the support is not court ordered;* **or** Provide a printout from the court or government agency through which payments are being made. (Last 6 months print out is required for deposits and dental programs).
FOOD STAMP ASSISTANCE	**$**	Monthly food stamp assistance from the State of Florida for single adults and families.
Business or Rental Net Income	**$**	Provide a copy of profit and loss statement; and provide the business bank statements.
Workmen's Compensation	**$**	Provide documentation from employer of amount and frequency of workmen's compensation.
Short- or Long-Term Disability	**$**	Provide documentation from employer of amount and frequency of disability compensation.
Recurring Contributions and Gifts	**$**	Provide a letter stating the amount and frequency of payment from the bank, attorney, or a trustee providing required verification; or A **Verification of Recurring Cash Contributions** (form) must be completed by the payee.
Other	**$**	Please provide documents of all other source of income in the household.

EXPENSES PAID MONTHLY

Childcare or Child Support Payments	**$**	**Car Insurance**	**$**
All Loan(s) other than Car, Real Estate, Mortgage and Student Loans	**$**	**Medical**	**$**
Rent, Real Estate & Mortgage Loans	**$**	**Food**	**$**
Electric & Water & Gas	**$**	**Gas (Automobile)**	**$**
Phone – (Including Cell Phone & Cable)	**$**	**All Credit Cards**	**$**
Car Payment(s)	**$**	**Student Loan(s) Other**	**$**

ASSETS AND ASSET INCOME

For ALL Household Members, Including Minors, List Checking and Savings Accounts, IRA, CD, Bonds, Stocks, Equity in Properties, Whole Life Insurance, Pensions, etc. All adults (18 years of age or older) in the household who do not have a financial account, must sign a **Verification of No Financial Accounts** (form). **(Please provide the last 6 months of Bank Statements or benefit statements for Deposit and Dental cases only)**

Type of Asset	Financial Institution	Account #
1.		
2.		
3.		
4.		

*If additional space to list assets is needed please attach information to the back of this application.

ADDITIONAL QUESTIONS

Please read and answer all questions below, additional documents are required for questions with an asterisk *.
Forms, in bold, are available in the Community Assistance Office or online with the application.

*Are copies of valid Florida Photo ID or valid Florida Driver's License for all adult household members (18 years of age or older) attached to the application? ☐Yes ☐No

*Are copies of Social Security Cards **and** birth certificates for all household members attached to application? ☐Yes ☐No

*Are you an employee or related to an employee of Seminole County Government? If yes, please list the relationship: ______________________________ ☐Yes ☐No

CITIZENSHIP/RESIDENCY:

Are you a U.S. citizen? ☐Yes ☐No

*If no, are you a permanent resident of the U.S.? *(If yes, a copy of the resident card must be provided.)* ☐Yes ☐No

LIVING ARRANGEMENTS:

*Is this a Section 8, Subsidized, TBRA or Public Housing Rental? ☐Yes ☐No

Note: Rent and Utility assistance cannot be provided to customers who have Section 8, TBRA, Shelter Plus Care or are with a Housing Authority

Are you homeless? ☐Yes ☐No

If yes, what are your current living arrangements? ☐ homeless shelter/facility ☐other, please state:

HEALTH:

Do you have Dental Insurance or a discount plan/policy? ☐Yes ☐No

Do you have Vision Insurance or a discount plan/policy? ☐Yes ☐No

Do you have Medicaid Insurance? ☐Yes ☐No

Do you have Medicare Insurance? ☐Yes ☐No

EDUCATION:

Are you a high school graduate? ☐Yes ☐No

If yes, year of graduation: ________________ If no, highest grade completed: ________________

Please list any college degrees or vocational training you have completed: ________________________________

Is Applicant, Co-Applicant, or any other household member 18 or older a full-time student? ☐Yes ☐No

EMPLOYMENT:

Are you currently seeking employment? ☐Yes ☐No

If no, explain: ____

VETERAN:

Are you a Veteran or Spouse/Dependent of a Veteran? ☐Yes ☐No

If yes to either question, may our Veteran Service Officer contact you? ☐Yes ☐No

REASONABLE ACCOMODATIONS:

Hearing impaired: Do you need TTD/TDY access to our staff? ☐Yes ☐No

Do you require accommodations for a disability? ☐Yes ☐No

If yes, what accommodations do you need? ____

We collect personal information directly from you for reasons that are discussed in our privacy statement. We may be required to collect some personal information by law or by organizations that give us money to operate this program. Other personal information that we collect is important to run our programs, to improve services for homeless individuals, and to better understand the need of homeless individuals. We only collect information that we consider to be appropriate.

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 and 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. The undersigned further understands that providing false representations herein constitutes an act of fraud. **Applicants that knowingly provide false, misleading or incomplete information will result in denial of application and barred from services from this office.**

***The Applicant, Co-Applicant, and any household member 18yrs and older must sign below.**

Applicant Signature **Date**	**Co-Applicant Signature** **Date**
Other Adult Member Sign Your Name	**Other Adult Member Sign Your Name**

THIS SECTION FOR OFFICIAL USE ONLY					
PROGRAM	☐SHIP ☐BCC	☐EHEAP ☐CDBG	☐ ESGP ☐CSBG	☐SCU ☐EFSP	☐ADDI ☐TBRA
Staff Signature:					
Supervisor Signature:					
Service Approved:					
Award Amount:					
Denied:					
Reason:					

SEMINOLE COUNTY COMMUNITY ASSISTANCE
AUTHORIZATION FOR THE RELEASE OF INFORMATION

Please print information, **do not use white-out**.

I ____, the undersigned, hereby authorize ____ to release by third party, without liability, information
(Leave this line blank, agency to complete)
in regards to employment, income, residency, dependency, or claims of loss or other confidential information pertaining to me and/or assets to the Seminole County Community Assistance Office, for the purposes of verifying information provided as part of determining eligibility for assistance under this application for assistance. I understand that only information necessary for determining eligibility can be requested. **This authorization is valid up to one year from date signed.**

TYPES OF INFORMATION TO BE VERIFIED:
I/We understand that previous or current information regarding me/us may be required. Verifications that may be requested are, but not limited to: employment history, hours worked, salary and payment frequency, commissions, raises, bonuses, and tips; cash held in checking/savings accounts, stocks, bonds, Certificates of Deposit, Individual Retirement Accounts, interest, dividends; payments from Social Security/SSI, annuities, insurance policies, retirement funds, pensions, disability or death benefits, unemployment, disability or worker's compensation, welfare assistance, net income from the operation of a business, and alimony or child support payments.

Organizations/individuals who may be asked to provide written/oral verifications are, but not limited to:

Past and Present Employers
Past and Present Landlords *(including Public Housing Agencies-TBRA/Section 8)*
Support and Alimony Providers
Hospitals/Doctors/Pharmacies/Clinics
Funeral Homes and Crematories

Welfare Agencies/Other Social Service Agencies and Non Profit Agencies
State Unemployment Agencies
Social Security Administration
Utility Companies

Veterans Administration
Retirement Systems
Banks and other Financial Institutions
Religious Organizations

CONDITIONS:
I/We agree that a photocopy of this authorization may be used for the purposes stated above. I/We understand I/we have a right to review this file and correct any information found to be incorrect.

____
Applicant Sign Your Name | Print Your Name | Date

____
Co-Applicant Sign Your Name | Print Your Name | Date

____
Other Adult Member Sign Your Name | Print Your Name | Date

____
Other Adult Member Sign Your Name | Print Your Name | Date

Note: This general consent may not be used to request a copy of a tax return or medical records.