



**Continuum of Care Membership Application**

**Organization:** \_\_\_\_\_ **Website:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Type of Membership**

Nonprofit Provider       Private Sector       Other: \_\_\_\_\_

Homeless Individual       Public Sector

If this application is being completed on behalf of an entity (e.g. a company, nonprofit), please complete the following questions:

1. Authorized Representative Name: \_\_\_\_\_ Email: \_\_\_\_\_

2. Who is authorized to vote in the CoC on behalf of your entity?

Primary Voting Delegate Name: \_\_\_\_\_ Email: \_\_\_\_\_

Secondary Voting Delegate Name: \_\_\_\_\_ Email: \_\_\_\_\_

Tertiary Voting Delegate Name: \_\_\_\_\_ Email: \_\_\_\_\_

**Subcommittees/Task Groups**

**I would like to serve on the following subcommittee?**

HMIS/Data Quality Committee       Rank and Review Committee

Coordinated Assessment/Entry Committee       Outreach/PIT Committee

Planning Committee       Faith Based

Service Delivery Committee

Fundraising/Resource Development Committee

Additional Categories Requested to meet HUD data requirements:

**If Private, Public or Nonprofit:**

- |   |  |
|---|--|
| <input type="checkbox"/> Law Enforcement/Corrections          | <input type="checkbox"/> Business: Industry _____          |
| <input type="checkbox"/> Local Government Agency              | <input type="checkbox"/> Faith-Based                       |
| <input type="checkbox"/> Local Workforce Investment Act Board | <input type="checkbox"/> Funder Advocacy Group             |
| <input type="checkbox"/> Public Housing Agencies              | <input type="checkbox"/> Hospitals/Medical Representatives |
| <input type="checkbox"/> School Systems/Universities          | <input type="checkbox"/> Non-Profit Organization           |
| <input type="checkbox"/> State Government Agencies            | <input type="checkbox"/> Other _____                       |

**Subpopulations Served:**

- |  |  |
|--|--|
| <input type="checkbox"/> Disabled                            | <input type="checkbox"/> Substance Abuse         |
| <input type="checkbox"/> Veterans                            | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> Domestic Violence                   | <input type="checkbox"/> Children (Under Age 18) |
| <input type="checkbox"/> Unaccompanied Youth (Ages 18 to 24) | <input type="checkbox"/> Families                |
| <input type="checkbox"/> LGBTQ+                              |  |

**Service Types Provided:**

- |   |   |
|---|---|
| <input type="checkbox"/> Emergency Shelter            | <input type="checkbox"/> Transitional Housing   |
| <input type="checkbox"/> Permanent Supportive Housing | <input type="checkbox"/> Rapid Re-housing       |
| <input type="checkbox"/> Prevention                   | <input type="checkbox"/> Outreach               |
| <input type="checkbox"/> Employment                   | <input type="checkbox"/> Food/Pantry            |
| <input type="checkbox"/> Health/Wellness              | <input type="checkbox"/> Mental/Behavior Health |

Membership information will be updated on an annual basis. Members are expected to attend general meetings. Meeting attendance is documented for community and county collaborative grant efforts. Failure to attend meetings has an adverse effect on the entire continuum.

**I acknowledge that for a membership to be considered in good standing, members must meet the CoC By-Laws definition of active membership under Article IV, Section D.**

---

Signature:

Title:

Date:

**Submit completed application to:**  
Seminole County Community Services  
534 West Lake Mary Blvd  
Sanford, Florida 32773 **Or**  
[clongsworth@seminolecountyfl.gov](mailto:clongsworth@seminolecountyfl.gov)