Seminole County Community Assistance Cremation/Burial Application

(Please print legibly in dark ink)

Name of Deceased	Deceased SS#	Date of Birth	Date of Death	Race	Marital Status	Age

Deceased Address	Apt. #	City Zip Code	Phone Number	Deceased Annual Income	City/County of Death

Name of Person Requesting Assistance	Relationship to the Deceased	Date of Birth	Race	Age

Address	Apt. #	City Zip Code	Phone Number	Person Requesting Assistance Annual Income	Email Address

Housing Status:

Homeowner____ Renter:____Homeless:_____ Shelter/Facility:_____ Live with Friend/Family:_____

Additional Members in Household of Deceased

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

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

Deceased Information

Funeral Home:_____

Funeral Home Contact:_____

Funeral Home Phone Number:_____

Is the deceased a Veteran? Yes:___ No:___ If yes please list the amount of VA benefits the deceased received. $_____

Has the death been reported to the Social Security Office? Yes: ____No:____

If yes, does the family of the deceased qualify for the $255.00 death burial benefit from Social Security Office? Yes:____No:___ If yes, please note that $255.00 will be deducted from any County payment of any approved case for assistance and the family will be responsible for paying the funeral home the $255.00 payment directly.

Does the deceased have life insurance? Yes: ____No:____

If yes, list the insurance company name, phone number and decease policy number.

_____

Does the deceased own property? Yes:____No:____

If yes list property address:_____

Was the deceased employed at the time of death? Yes___No___

If yes, list employer's name and phone number:

_____

Does the deceased have a bank account? Yes____No:____

If yes, list name of the bank and provide the latest bank statement.

_____

Does the deceased and requesting person meet 100% of the Poverty Income Guidelines listed below? Yes:____No:____ If no, please explain why county assistance is required.

_____

_____

100% Poverty Level Gross Annual Household Income

1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 Persons
$12,490	$16,910	$21,330	$25,750	$30,170	$34,590	$39,010	$43,430

For each additional family member add $4,420

Additional Members in Applying Person Household

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

Name(s)	Social Security #	Date of Birth	Age	Relationship
1				
2				
3				
4				
5				

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 Section 817.03 Florida Statute provides that making false statements or misrepresentation relating to financial condition, assets or liabilities is a misdemeanor of the first degree, punishable by fines and imprisonment as provided under sections 775.082 or 775.83, Florida Statutes. I/we further understand that any willful misstatement of information will be grounds for disqualification. 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.

I/We agree to indemnify, release and hold Seminole County, its officers, employees and agents harmless from any and all liability, including all fees and costs, resulting from claims, losses, damages or causes of action (including attorney's fees and expenses of litigation) in connection with the cremation and disposition of the cremated remains of the deceased.

Requesting Person Signature:_____ **Date:**_____

COMMUNITY ASSISTANCE USE ONLY:

INTAKE: _____

ASSIGNED CASE MANAGER: _____

OUTCOME: _____

_____

TIME/DATE STAMPED: