Application for Financial Assistance

1. Please read the instructions thoroughly before beginning to complete the application.

2. Please complete the entire form. Incomplete applications can lead to processing delays or disqualification.

3. This application is step 1 of 3 in the assistance process. You will be asked to submit more information based on the type of assistance you need. Please do not send any documents other than the application at this time. Once a case manager reviews your file, they will request the information they need. Too much information can delay response time in the same way an incomplete application can cause delays.

4. Due to the volume of applications we receive daily, it could take 5-7 days before we review your application. Please be patient and refrain from calling to inquire about the status of your application as it slows the review process. Phone calls will be made to applicants on Mondays and Wednesdays regarding status and needed documents.

5. If you have problems submitting the application, you may pick up a paper copy at our office, located at 1204 14th Street West. Applications are available from 9 am until 4 pm, Monday through Friday.

6. Please save a copy of the application to your computer and email your completed application to FLABradenton.SocialServices@uss.salvationarmy.org.

CRF DISASTER PROGRAM INTAKE APPLICATION

INSTRUCTIONS FOR APPLICATION

General Instructions

Read the instructions for this application.

Please type or use BLUE or BLACK ink. Do not use pencil or other colors of ink. Please write legibly. All blanks must be completed or have N/A written in.

All household members 18 years of age or older must sign and date the application.

Submit application with all the required documentation to: {Insert electronic and postal information}.

Itemized Instructions

1. **APPLICANT INFORMATION**: Provide your legal name, an address where you receive your mail, an e-mail address (if applicable), your date of birth, and your marital status and other fields.
2. **CO-APPLICANT/OTHER HOUSEHOLD MEMBER INFORMATION**: List all other members of the household residing in the unit. Attach additional sheets if necessary.
3. **ALTERNATE CONTACTS INFORMATION**: This information is being collected to assist us in locating you in the event that you move or are living temporarily in another location. List contacts who are helping you through this process, if applicable.
4. **HOUSEHOLD COMPOSITION AND CHARACTERISTICS**: As of today, list the current Head of Household and all other members of the household. Indicate the relationship of each family member to the Head of Household, date of birth and marital status. Indicate if any of the members listed are disabled and explain if there are any expected additions to the future household, e.g. birth of a child, adoption, legal custody ruling resulting in an additional household member.
5. **RACE AND ETHNICITY FOR HEAD of HOUSEHOLD**: This information is collected for reporting purposes only.
6. **ELIGIBILITY INFORMATION**: The information collected here is important to determine eligibility as it relates to emergency assistance.
7. **COVID-19 INFORMATION**: Provide basic information concerning eligibility related to the public health emergency with respect to COVID-19. Provide information on whether you or a household member was directly affected by COVID-19.

a. Agreement to turn over Proceeds; Future Reassignment.

If the applicant has received or receives any Proceeds from any source that covers the expenses covered by the CRF assistance provided, the applicant agrees to promptly pay such amounts to the City/County.

b. In the event that the applicant received, receives or is scheduled to receive any Proceeds not previously disclosed to the City/County the applicant shall notify the City/County of such Subsequent Proceeds, and the City/County will determine the amount, if any, of such Subsequent Proceeds that are a duplication of benefits (DOB). Subsequent Duplication of Benefits proceeds shall be disbursed as follows:

(1) If the Award has been fully expended by the City/County, any Subsequent DOB Proceeds shall be paid by applicant to the City/County up to the amount of the Award.

(2) If no portion of the Award has been expended by the City/County, any Subsequent DOB Proceeds shall be paid by applicant to the City/County and used to reduce the Award. If the application of the

Subsequent DOB Proceeds would reduce the Award to zero, all Subsequent DOB Proceeds and any funds previously paid by the applicant to the City/County shall be returned to the applicant, and this Agreement shall terminate.

(3) If some portion of the Award has been expended by the City/County, any Subsequent DOB Proceeds shall be used, retained and/or disbursed in the following order: (1) Subsequent DOB Proceeds shall first be paid by applicant to the City/County to reduce the unexpended portion of the Award; (2) if the application of the Subsequent DOB Proceeds would reduce the unexpended Award to zero, any remaining Subsequent DOB Proceeds shall be applied to expended portion of the Award and retained by the City/County; (3) if the application of the Subsequent DOB Proceeds reduces both the unexpended and the expended portions of the Award to zero, any remaining Subsequent DOB Proceeds shall be returned to the applicant, and this Agreement shall terminate.

(4) If the City/County makes the determination that the applicant does not qualify to participate in the Program or the applicant decides not to participate in the Program, the Subsequent DOB Proceeds and any funds previously paid by the applicant to the City/County that have not been used or obligated by the Program shall be returned to the applicant, and this Agreement shall terminate.

(5) Once the City/County has recovered an amount equal to the Award, the City/County will reassign to applicant any rights assigned to the City/County pursuant to this Agreement.

8. OTHER ASSISTANCE RECEIVED: Provide all information any other type of related assistance to the disaster.

9. INCOME INFORMATION: Provide information on all household income sources. Income includes the following: Wages, salaries and tips, alimony, child support, military income, part-time income, temporary income, TANF, Social Security, other benefits, and other income for all household members. Food benefits are NOT considered income.

10. ASSET INFORMATION: Provide the requested information on assets for all household members. Examples of what constitutes assets are listed below:
Typical assets include:

- Cash held in savings, checking accounts, safe deposit boxes, homes, etc.;
- Stocks, bonds, treasury bills, CDs, mutual funds, money market accounts, and other investment accounts;
- Individual retirement accounts, 401(k), Keogh accounts, annuities, and other similar retirement savings accounts;
- Cash value of life insurance policies available to the holder before death;
- Personal property that is held for investment purposes;
- Equity in real property;
- Retirement and pension funds;
- Mortgage or deeds of trust held by the applicant

Some items of personal property are ***NOT*** counted as assets for the purposes of determining annual income:

- Automobiles;
- Jewelry; and/or
- Term life insurance policies

11. FALSE STATEMENTS

Chapter 817 of the Florida Statutes provides that willful false statements or misrepresentation concerning income and assets or liabilities relating to financial condition is a misdemeanor of the first degree and is punishable by fines and imprisonment provided under §775.082 or 775.083.

Applicant is hereby notified that intentionally or knowingly making a materially false or misleading written statement relating to the Program could result in ineligibility for benefits, action to recover any Program benefits paid to or on behalf of applicant, and/or a referral to criminal law enforcement. Applicant represents that all statements and representations made by applicant regarding Proceeds received by applicant have been and shall be true and correct.

12. PUBLIC RECORDS DISCLOSURE AND ACKNOWLEDGMENT

Information provided by the applicant(s) may be subject to Chapter 119, Florida Statutes, regarding Open Records.

Information provided by you/your household that is not protected by Florida Statutes can be requested by any individual for their review and/or use. This is without regard as to whether or not you qualify for funding under the program(s) for which you are applying. Having been advised of this fact prior to finalizing the application for assistance or supplying any information, your signature below indicates that:

I/We agree to hold harmless and indemnify the City/County, any governmental agency, its officers, employees, stockholders, agents, successors and assigns from any and all liability and costs that may arise due to compliance with the provisions of Chapter 119, Florida Statues.

I/We agree that the City/County does not have any duty or obligation to assert any defense, exception, or exemption to prevent any or all information given to the City/County in connection with this application, or obtained by them in connection with this application, from being disclosed pursuant to a public records law request.

I/We agree that the City/County does not have any obligation or duty to provide me/us with notice that a public records law request has been made.

I/We agree to hold harmless the City /County or any governmental agency, its officers, employees, stock holders, agents, successors and assigns from any and all liability that may arise due to my/our applying for assistance.

13. ELIGIBILITY RELEASE: It is required that you sign this form, which allows the Subrecipient, State or Vendor to request information from Third Parties if it chooses to do so, concerning your eligibility and participation in this program. This form allows for income, assets, child support, etc. to be verified and documented.

_____	_____
Applicants Signature	Date
_____	_____
Household Member	Date
_____	_____
Household Member	Date
_____	_____
Household Member	Date

Suncoast Continuum of Care

RELEASE OF INFORMATION

Authorization to Use or Disclose Personal Information including Protected Health Information (PHI)

Name:	Social Security Number: XXX-XX-___ ___ ___ ___	Date of Birth:
Name of Provider Agency: The Salvation Army, Manatee County		

I authorize the use or disclosure of personal information, including protected health information, about the individual named above.

I am: ☐ the individual named above
☐ a personal representative because the person is a minor, incapacitated, or deceased

The Salvation Army, Manatee County participates in the Sarasota/Manatee Continuum of Care (FL-500) coordinated entry system (Oneby1) and/or the Homeless Management Information System (HMIS). These systems include organizations that provide homeless and housing assistance and supportive services. As part of HMIS and the Oneby1 system, agencies agree to share information about individuals and families with other agencies in order to coordinate services and help a household find and/or keep housing as quickly as possible.

The information to be disclosed may include personal information contained within the Homeless Management Information System, records from providers detailing my medical conditions and including information on disabilities, mental health, drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection, AIDS, and other communicable disease test results and diagnoses. Information contained within the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT), the Service Prioritization Decision Assistance Tool (SPDAT), other assessment forms, and other information collected as part of case management, case planning and case conferencing will be shared in HMIS and as it relates to the coordination of services for housing placement and stability.

Important Rights and Other Required Statements You Should Know

You can revoke this authorization at any time by writing to the Suncoast Partnership to End Homelessness, Inc., 1750 17th Street / K-1, Sarasota, FL 34234. If you revoke this authorization, it will not apply to information that has already been used or disclosed.

You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to Suncoast Partnership to End Homelessness, Inc. 1750 17th Street / K-1 Sarasota, Florida 34234.
If you have any questions about anything on this form, or how to fill it out, we can help. Please call the Suncoast Partnership at 941-955-8987.

This authorization will expire two (2) years from the date this document was signed by the individual or personal representative below.

By signing this authorization, I am attesting that I understand: *(Initial each line)*

_____The reason I am being asked to release information

_____My protected health information, including, but not limited to, mental health, drug & alcohol, HIV/AIDS information can be shared with partner providers and HMIS participating organizations. I understand that agencies participating may change from time to time and that a copy of the current list of agencies is available upon request from the Suncoast Partnership by calling 941-955-8987.

_____The HMIS operates over the internet and uses many security protections to ensure the complete confidentiality of my records.

_____Signing this authorization is voluntary, and I do not have to agree to authorize any use or disclosure. I understand that the ability to receive services or support is not conditioned upon authorizing this disclosure. However, by not giving authorization to share information, I may not be able to access housing help as quickly as possible and that some services that result from a coordination of activities between providers may be limited in availability. Some agencies require certain questions to be answered in order to determine eligibility for their projects.*

_____The providers that have access to my protected health information are prohibited from re-disclosing information outside of the terms of his release of information form, without my written authorization except as permitted by federal or state law.

Signature: _____ **Date (required):** _____

Dependent(s) that the Legal Guardian Authorizes to Participate in the SMHMIS:

Name: _____	DOB: _____/_____/_____	Name: _____	DOB: _____/_____/_____
Name: _____	DOB: _____/_____/_____	Name: _____	DOB: _____/_____/_____
Name: _____	DOB: _____/_____/_____	Name: _____	DOB: _____/_____/_____
Name: _____	DOB: _____/_____/_____	Name: _____	DOB: _____/_____/_____

Signature of Personal Representative (if applicable)

Signature: _____ Date: _____

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare and services. You may be asked to provide us with the relevant legal document giving you this authority.

Relationship to the individual (required): _____

Signature of Witness:

Signature: _____ Date: _____

*Agencies may have additional requirements that must be agreed upon by the participant. If applicable, these requirements will be listed on the following pages.

HOUSING INTAKE APPLICATION

Application Number:	
Application Received By:	Date/Time Application Received:
What type of housing assistance are you requesting? Circle all that apply Rent ☐ Mortgage ☐ HOA fees ☐ Electric ☐ Water ☐ Gas ☐	
Other (Explain)	
TO BE COMPLETED BY APPLICANT: (Head of Household)	
Full Name:	
Current Address:	**Apt#**
City, State Zip:	
Daytime phone:	**Mobile Phone:**
E-mail Address:	**Date of Birth:**
Marital Status:	**Age:**
Employed? Yes ☐ No ☐	**Self Employed? Yes ☐ No ☐**
1. TO BE COMPLETED BY CO-APPLICANT:	
Full Name:	
Daytime phone:	**Mobile Phone:**
E-mail Address:	**Date of Birth:**
Marital Status:	**Age:**
Employed? Yes ☐ No ☐	**Self Employed? Yes ☐ No ☐**

4. HOUSEHOLD COMPOSITION, CHARACTERISTICS AND FAMILIAL STATUS: - As of today, all other members of the household. Indicate the relationship of each family member to the Head of Household (spouse, sibling, etc.). In addition, indicate if there are any additional members in the near future to the household.

Household Member Name	Relationship to Head of HH	Age	Date of Birth	Marital Status	Is household member listed disabled? Y/N	Employed
						Yes No
						Yes No
						Yes No
						Yes No
						Yes No

5. RACE AND ETHNICITY FOR HEAD of HOUSEHOLD (Check one): -This information is being collected for reporting purposes only.

RACE (Check all that apply):

☐ American Indian or Alaska Native	☐ Asian
☐ Native Hawaiian or Other Pacific Islander	☐ White
☐ Black or African American	☐ Other Multi-Racial

ETHNICITY (Check one):

☐ Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

☐ Non-Hispanic or Latino - A person not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

ELIGIBILITY INFORMATION: - If the answer to any of the following questions is NO, you are not eligible for assistance:

Were you or a household member affected by the COVID-19?	YES	NO
How many household members are affected by COVID-19?		
For each Household member affected by COVID-19, provide the following information:		
1st household member affected by COVID-19		
Name:		
Are they unemployed or underemployed due to COVID-19?	YES	NO
Date person became unemployed or under employed		
Name and address of employer prior to being impacted by COVID-19:		

What was the annual gross income of this person prior to being affected by COVID-19 or March 1, 2020 whichever is later?		
Current employer:		
What was the projected annual gross income of this household after being affected by COVID-19?		
Is the person receiving unemployment benefits? Yes ☐ or No ☐		
If yes, how much are they receiving monthly $		
Provide additional information about Hardship:		
2nd household member affected by COVID-19		
Name:		
Are they unemployed or underemployed due to	YES	NO
Date the person became unemployed or under		
Name and address of employer prior to being impacted by COVID-19:		
What was the annual gross income of this person prior to being affected by COVID-19 or March 1, 2020 whichever is later?		
Current employer:		
What was the projected annual gross income of this household after being affected by COVID-19?		
Is the person receiving unemployment benefits? Yes ☐ or No ☐		
If yes, how much are they receiving monthly $		

Provide additional information about Hardship:

Property Information		
Do you rent or own a pre-1994 mobile or manufactured home?	YES	NO
Are you past due or delinquent on your rent, mortgage or utilities?	YES	NO
What is your monthly rent payment?		
What is your monthly mortgage payment?		
What is your average monthly electric payment?		
What are the penalties due, if any?		
How many months of rent are past due?	Amount Due	
How many mortgage payments are past due?	Amount Due	
How many months of HOA fees are past due?	Amount Due	
How many months of utilities are past due?	Amount Due	
The following question will require a special review to determine eligibility:		
Did you apply for COVID-19 assistance to any other program or organization?	YES	NO

Explain:

Have you received any COVID related assistance?	Yes	No
Amount Approved?	Amount Received to date:	

List agency providing services	1
	2
	3
If yes, explain the type of assistance you received e.g. Red Cross, United Way, previous federal or state assistance (CRF, CDBG, CDBG-DR, HOME), etc.	Yes No

INCOME INFORMATION: Income includes: Wages, salaries and tips, alimony, child support, military income, part-time income, temporary income, TANF, Social Security, unemployment benefits, other benefits for all household members. List ALL household members and their incomes. Attach a separate sheet if you need more space.

FOOD STAMPS ARE NOT CONSIDERED INCOME- do not list food stamps.

Household Member Name	Full Time Student? Y/N	Source of Income (include employer name) If Applicable	Rate of Pay	Payment Basis (hourly, weekly, monthly, etc.)

ASSET INFORMATION: Provide the requested information on any property you may own or assets you may have.

Do you own any other real estate?	Yes No N/A
If yes, provide address, city and state of property(s):	

What is the tax roll value of the property?	☐ Yes ☐ No
If yes, what is the current balance owed on the mortgage?	
Do you have income from the property? (rental income)	☐ Yes ☐ No
If you answered yes, provide amount of annual income	$
Is your primary residence currently in foreclosure?	☐ Yes ☐ No

List below the types and sources of any household assets. Provide both the current cash value and the estimated annual income from the asset. (A listing of examples is located in the instruction section.) Provide this information for all household members.

Household Member Name	Type & Source of Asset	Cash Value of Asset	Annual Income from Asset

ELIGIBILITY RELEASE: It is required that you sign this form, which allows the City/County, subrecipient, sponsor, State or Vendor to request information from Third Parties concerning your eligibility and participation in this program.

Information Covered: Inquiries may be made about items initialed below by the applicant.

Instructions to Applicant: Your signature on this Eligibility Release, and the signatures of each member of your household who is 18 years of age or older, authorizes the City/County or any of its duly authorized representatives to obtain information from a third party regarding your eligibility and continued participation in the CRF Program for disaster assistance. Each adult member of the household must sign this Eligibility Release.

Information provided by the applicant(s) may be subject to Chapter 119, Florida Statutes, regarding Open Records.

APPLICANT CERTIFICATION: Certify that all the information in the application is true, to the best of your knowledge. By signing this application to verify the information contained, the applicant authorizes the City/County or any of its duly authorized representatives to verify the information listed herein.

I/We understand the information provided above is collected to determine if I/we are eligible to receive assistance under the CRF program.
I/We hereby certify that all the information provided herein is true and correct.
I/We understand that providing false statements or information for the purpose of obtaining assistance is grounds for termination of housing assistance and is punishable under Chapter 817 of the Florida Statutes as a first-degree misdemeanor.
I/We authorize the above-referenced City/County/subrecipient/sponsor and any of its duly authorized representatives to verify all information provided in this application.
I/We understand that additional information will likely be required to move forward with this program.

Applicant's Authorization:
I authorize the above-named Subrecipient, Sponsor, State or Vendor to obtain information about me and my household that is pertinent to determining my eligibility for participation in the Program. I acknowledge that:
(1) A photocopy of this form is as valid as the original; AND
(2) I have the right to review information received using this form; AND
(3) I have the right to a copy of information provided to the Subrecipient and to request correction of any information I believe to be inaccurate; AND
(4) All adult household members will sign this form and cooperate with the Subrecipient in the eligibility verification process.
(5) If the applicant falsified information to obtain assistance, all funds paid on behalf of the applicant must be repaid to the program.

Signature of Applicant:	**Date**
Signature of Co-Applicant:	**Date**
Household member:	**Date**
Household member:	**Date**
Household member:	**Date**
Household member:	**Date**
Household member:	**Date**
Household member:	**Date**
Household member:	**Date**
Household member:	**Date**

Warning: Chapter 817 of the Florida Statutes provides that willful false statements or misrepresentation concerning income and assets or liabilities relating to financial condition is a misdemeanor of the first degree and is punishable by fines and imprisonment provided under §775.082 or 775.083.