HURRICANE HOUSING RECOVERY PROGRAM
APPLICATION FOR HOUSING ASSISTANCE

Type of Assistance: (Circle One) **Annual Income: $ _____**
Purchase Assistance / Rehabilitation / Demo-Reconstruction **Income Category (VL, LI, MI): _____**

Applicant/Co-Applicant General Information	Applicant	Co-Applicant
Full Name:		
E-mail:		
Date of Birth/Age:		
Street Address:		Phone:
City:		State/Zip:
Mailing Address:		Phone:
City:		State/Zip:

Other Household Members:

Name(s)	Date of Birth/Age	Relationship to Applicant

Is Applicant, Co-Applicant, or any other household member, age 18 or older, a full-time student? If yes, please list:_____

Does Applicant/Co-Applicant own a home? Yes_____No_____

Monthly rent/mortgage: $ _____

If No, type of unit to be purchased?_____existing unit ____newly constructed unit

Applicant/Co-Applicant Employment Information:

Employee Name:	Employer Name:	
Position:	Supervisor:	
Address/Phone:		Time Employed:
Pay Rate:		Pay Frequency:
Annual Income (gross salary, overtime, tips, bonuses, etc.): $		

Employee Name:	Employer Name:	
Position:	Supervisor:	
Address/Phone:		Time Employed:
Pay Rate:		Pay Frequency:
Annual Income (gross salary, overtime, tips, bonuses, etc.): $		

NOTE: Attach additional sheets as necessary for all household members 18 years and over

Other Sources of Income (For ALL Household Members including minors, List Business or Rental Net Income, Child Support, Alimony, Social Security, Pensions, Unemployment or Workers Compensation, Welfare Payments, etc.)

Name	Type of Income	Gross Annual Amount
1.		
2.		
3.		
4.		
		Total: $ _____

Assets and Asset Income (For ALL Household Members, Including Minors, List Checking and Savings Accounts, IRA, CD, Bonds, Stocks, Equity in Properties, etc.)

Type of Asset	Asset Value	Bank/Account #	Annual Asset Income
1.			
2.			
3.			
4.			
	Total: $ _____		Total: $ _____

Liabilities (For ALL Household Members 18 and Over, List Credit Card Debt, and Auto, Real Estate and Mortgage Loans, etc.)

Type Credit/Loan	Creditor's Name	Balance Owed	Monthly Payment
1.			
2.			
3.			
4.			
		Total Annual Payments: $	

Ethnicity/Special Needs *(For reporting purposes only, please check all that apply for Head of Household Only)*: White_____ Black_____ Hispanic_____Asian/Pacific Islander _____

Native American_____Farmworker _____ Disabled or Disabled Minor _____ Elderly ___

Homeless_____ Special needs_____ other_____

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.

Applicant Signature	Date	Co-Applicant Signature	Date
Household member (over 18)	Date	Household member (over 18)	Date
Household member (over 18)	Date	Household member (over 18)	Date

(To Be Completed For All Household Members, Including Minors)

State and/or Federal Regulations require us to verify asset income information for the person who has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is most appreciated. A self-addressed return envelope is enclosed or you may fax to:

Authorization:

I hereby authorize the release of requested information. A copy of the executed "Authorization for the Release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

_____ _____ _____

Signature of Applicant/Co-Applicant/Household Member Print Name Date

Please return information to:

Name: **Naomi L. Lanier** Title: **S.H.I.P. Administrator**

Department **S.H.I.P.**

Address: **1000 Cecil G. Costin Sr., Blvd., Room 311, Port St. Joe, FL 32456**

Complete the (applicable) Sections below:

Institution Name:_____Checking Account #:_____

Average Monthly Balance (last 6 months): $_____Interest Rate: _____

Savings Account #:_____Balance/Interest Rate: $_____,_____%_____

Certificate of Deposit #:_____Amount: $ _____

Interest Rate:_____Withdrawal Penalty: $ _____

IRA, Keogh, Retirement Account #:_____Amount: $ _____

Interest Rate:_____Withdrawal Penalty; $ _____

Other Account #:_____Amount/Interest Rate: $_____, _____%_____

Signature of authorized representative: _____

Printed Name:_____Title: _____

Date:_____Phone: _____

WARNING: 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.

NOTE: For ALL Household Members, including minors, obtain a signed copy of this form for each verification to be completed. Send form directly to depository institution; do not send form through applicant. Upon receiving verification, date-stamp, and compare information to that received on application. Make any necessary notations, date and initial. If significant differences exist between amount reported and verified, obtain a written explanation from applicant and attach to file.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I_____, the undersigned, hereby authorize_____to release without liability, information regarding my employment, income, and/or assets to **Gulf County S.H.I.P. Program**, for the purposes of verifying information provided as part of determining eligibility for assistance under the **H.H.R.P.** program. I understand that only information necessary for determining eligibility can be requested.

Types of Information to be verified:

I understand that previous or current information regarding me 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, certificated of deposits, Individual Retirement Accounts, interest, dividends; payments from Social Security, 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 that may be asked to provide written/oral verifications are, but not limited to:

Past/Present Employers
Institutions

Welfare Agency

Alimony/Child Support Providers Banks, Financial or Retirement
Social Security Administration State Unemployment Agency
Veteran's Administration
Other: _____

Agreement to Conditions:

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

Signature of Applicant/ Printed Name Date

Co-applicant Printed Name Date

Note: This general consent may not be used to request a copy of a tax return. If one is needed, contact your local IRS office or go online for Form 4506-T, "Request for Copy of Tax Return" and prepare and sign separately.

Verification of Child Support Payments

State and/or Federal Regulations require us to verify of child support payments made to the person that has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is most appreciated. A self-addressed return envelope is enclosed, or you may fax or email to:

Authorization:

I hereby authorize the release of requested information. A copy of the executed "Authorization for the Release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

_____ _____ _____

Signature of Applicant Print Name Date

_____ _____ Co-

Applicant/Household Member Print Name Date

Please return information to (attach transcript):

Name: **Naomi L. Lanier** Title: **S.H.I.P. Administrator**

Department **S.H.I.P.**

Address: **1000 Cecil G. Costin Sr., Blvd., Room 311, Port St. Joe, FL 32456**

Complete the Sections below:

Name of person paying child support:

Address:_____City_____State_____Zip _____

Children's names: _____

Amount of support $_____ ___weekly ____monthly ____yearly

Signature of Authorized

Representative:_____

Printed Name:_____Title:_____

Date:_____Phone: _____

WARNING: 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.

THIRD-PARTY VERIFICATION OF INCOME FROM BUSINESS

State and/or Federal Regulations require us to verify business income information for the person that has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is most appreciated. A self-addressed return envelope is enclosed or you may fax to: **(850) 229-7180** or email to: **ship@gulfcounty-fl.gov.**

Authorization:
I hereby authorize the release of requested information. A copy of the executed "Authorization for the Release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

_____	_____	_____
Signature of Applicant/Co-Applicant/Household Member	Print Name	Date

Please return information to:

Name: **Naomi L. Lanier** Title: **S.H.I.P. Administrator**

Department: **S.H.I.P.** Phone: **(850) 229-6125**

Address: **1000 Cecil G. Costin Sr., Blvd., Room 311, Port St. Joe, FL 32456**

Complete the (applicable) Sections below:

Dates Business Transacted from:_____ Expenses (Provide Amounts for Applicable Expenses): Gross Income: _____

Interest on Loans:	**$**	**Costs of goods/materials:**	**$**
Rent:	**$**	**Utilities:**	**$**
Wages/Salaries:	**$**	**Employee Contributions:**	**$**
Federal Withholding Tax:	**$**	**State Withholding Tax:**	**$**
FICA:	**$**	**Sales Tax:**	**$**
Other:	**$**	**Other:**	**$**

Straight Line Depreciation: $ **Total Expenses: Net Income: $**

Signature of Authorized Representative:_____

Printed Name:_____ T i t l e: _____

Date:_____ Phone:_____

WARNING: 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.

Verification of Pensions and Annuities

State and/or Federal Regulations require us to verify pension and annuity benefits made to the person that has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is most appreciated. A self-addressed return envelope is enclosed, or you may fax to: **(850) 229-7180** or email to: **ship@gulfcounty-fl.gov.**

Authorization: I hereby authorize the release of requested information. A copy of the executed "Authorization for the Release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

_____ _____ _____

Signature of Applicant Print Name Date

_____ _____ _____

Co-Applicant/Household Member Print Name Date

Please return information to:

Name: **Naomi L. Lanier** Title: **S.H.I.P. Administrator**

Department: **S.H.I.P.** Phone: **(850) 229-6125**

Address: **1000 Cecil G. Costin Sr., Blvd., Room 311, Port St. Joe, FL 32456**

To: Name of Institution_____

Address:_____ City:_____ State:_____ Zip:_____

Complete the Sections below:

Current monthly gross amount of pension or annuity: $_____

Deduction from Gross for Medical insurance premiums

Date of initial award $_____ Effective date of current amount

Expected change in current amount:_____ New amount $_____

Contribution to company retirement/pension fund $_____

Amount received in lump sum $_____ Date_____

Signature of authorized representative: _____

Printed Name:_____ Title:

Date:_____ Phone: _____

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THIRD-PARTY VERIFICATION OF REGULAR CASH CONTRIBUTIONS
(i.e. Paying Rent, Regular Family Assistance, Alimony, etc.)

State and/or Federal Regulations require us to verify regular cash contributions made to the person who has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is most appreciated. A self-addressed return envelope is enclosed, or you may fax to: **(850) 229-7180** or email to: **ship@gulfcounty-fl.gov.**

Authorization:

I hereby authorize the release of requested information. A copy of the executed "Authorization for the Release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

_____	_____	_____
Signature of Applicant/Co-Applicant/Household Member	Print Name	Date

Please return information to:

Name: **Naomi L. Lanier** Title: **S.H.I.P. Administrator**

Department: **S.H.I.P.** Phone: **(850) 229-6125**

Address: **1000 Cecil G. Costin Sr., Blvd., Room 311, Port St. Joe, FL 32456**

Complete the Sections below:

Type of Cash Contribution:_____ Amount: $_____

Frequency of Contribution (Wk., Mo):_____Will Payments Continue (Y or N): _____

Signature of Authorized Representative:_____

Printed Name:_____ Title:_____ Date:_____Phone:_____

WARNING: 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 775.83.

NOTE: For ALL applicable Household Members 18 years or over, obtain a signed copy of this form for each verification to be completed. Send form directly to the appropriate person/agency; do not send form through applicant. Upon receiving verification, date-stamp, and compare information to that received on application. Make any necessary notations, date and initial. If significant differences exist between amount reported and verified, obtain a written explanation from applicant and attach to file.

THIRD-PARTY VERIFICATION OF SOCIAL SECURITY BENEFITS

State and/or Federal Regulations require us to verify Social Security Benefit income for the person who has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is most appreciated. A self-addressed return envelope is enclosed, or you may fax to **(850) 229-7180** or email to: **ship@gulfcounty-fl.gov.**

Authorization:

I hereby authorize the release of requested information. A copy of the executed "Authorization for the Release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

_____ _____ _____

Signature of Applicant/Co-Applicant/Household Member Print Name Date

Please return information to:

Name:_____Title:_____

Department:_____Phone: _____

email_____

Address:_____

Complete the Sections below:

Date of Birth:_____Social Security #:_____

Type of Social Security Benefit:_____Gross Monthly Amount: $ _____

Type of Supplemental Security Benefit:_____Gross Monthly Amount: $ _____

Deduction for Medicare (Y or N):_____If yes, Amount Deducted: $ _____

Signature of Authorized Representative:_____

Printed Name:_____Title:_____

Date:_____Phone:_____

WARNING: 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 775.83.

NOTE: For ALL applicable Household Members 18 *years or over, obtain a signed copy of this form for each verification to be completed. Send form directly to the appropriate administration; do not send form through applicant. Upon receiving verification, date-stamp, and compare information to that received on application. Make any necessary notations, date and initial. If significant differences exist between amount reported and verified, obtain a written explanation from applicant and attach to file.*

THIRD-PARTY VERIFICATION OF UNEMPLOYMENT BENEFITS

State and/or Federal Regulations require us to verify unemployment benefit income for the person who has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is must appreciated. A self-addressed return envelope is enclosed, or you may fax to: **(850) 229-7180** or email to: **ship@gulfcounty-fl.gov.**

Authorization:

I hereby authorize the release of requested information. A copy of the executed "Authorization for the Release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

_____	_____	_____
Signature of Applicant/Co-Applicant/Household Member	Print Name	Dat

Please return information to:

Name: **Naomi L. Lanier** Title: **S.H.I.P. Administrator**

Department: **S.H.I.P.** Phone: **(850) 229-6125**

Address: **1000 Cecil G. Costin Sr., Blvd., Room 311, Port St. Joe, FL 32456**

Complete the Sections below:

Are Benefits being paid now (Y or N):_____If Yes, Gross Weekly Payments: $ _____

Date of Initial Payment:_____Duration of Benefits: _____

Claimant Eligible for Future Benefits (Y or N):_____If Yes, provide # of weeks: _____

If No, Provide Date of Benefits Termination: _____

Signature of authorized representative: _____

Printed Name:_____Title: _____

Date:_____Phone: _____

WARNING: 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.

NOTE: For ALL applicable Household Members 18 years or over, obtain a signed copy of this form for each verification to be completed. Send form directly to the appropriate agency; do not send form through applicant. Upon receiving verification, date-stamp, and compare information to that received on application. Make any necessary notations, date and initial. If significant differences exist between amount reported and verified, obtain a written explanation from applicant and attach to file.

THIRD-PARTY VERIFICATION OF EMPLOYMENT

Note to employer: Please provide information about anticipated income during the next 12 months only.

State and/or Federal Regulations require us to verify employment history and income information for the person who has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is most appreciated. A self-addressed return envelope is enclosed, or you may fax to: **(850) 229-7180** or email to: **ship@gulfcounty-fl.gov.**

Authorization:
I hereby authorize the release of requested information. A copy of the executed" Authorization for the release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

_____

Signature of Applicant Print Name Date
Co-Applicant/Household Member

Please return information to:

Name: **Naomi L. Lanier** Title: **S.H.I.P. Administrator**
Department: **S.H.I.P.** Phone: **(850) 229-6125**
Address: **1000 Cecil G. Costin Sr., Blvd., Room 311, Port St. Joe, FL 32456**

Position:_____Date of hire:_____Probability of continued employment (Y or N)
Current Pay Rate:_____Pay Frequency (Hr., Wk., Mo):_____per _____
Overtime Pay Rate:_____Expected overtime hours during the next 12 months: _____
Total anticipated Annual Base Pay Earnings for the next 12 months: _____
Total anticipated Overtime Base Pay Earnings for the next 12 months: _____
Probability and expected date of any pay increase_____Amount of increase_____New rate of Pay _____

Amount of Other Compensation anticipated during the next 12 months (bonus, commission, tips): $ _

Vacation Pay (Y or N): _____if yes, number of days: _____ Retirement Account (Y or N) Amount Accessible to Employee: _____

Penalty for withdrawal (Y or N) Penalty Amount _____

Total anticipated Gross Annual Income, including other compensation, for next 12 months: ____

Signature of authorized representative: _____

Printed Name:_____Title: _____

Date: _____Phone: _____

NOTE: For ALL applicable Household Members 18 years or over, obtain a signed copy of this form for each verification to be completed. Send form directly to the appropriate employment source; do not send form through applicant. Upon receiving verification, date-stamp, and compare information to that received on application. Make any necessary notations, date and initial. If significant differences exist between amount reported and verified, obtain a written explanation from applicant and attach to file.
WARNING: 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.

Verification of Verbal

APPLICANT INFORMATION

Name:_____

Address:_____Phone: _____

Type of Assistance: Homebuyer _____ Homeowner Rehab_____Emergency Repair _____

Other:

Type of Information being verified: Employment ____ Household_____ Assets _____

Other:

Name of Entity being contacted:_____Phone number:_____

Name of person contacted:_____Title: _____

Notes:

_____ _____ _____

Signature (Receiving Verbal Verification) Date of Verbal Verification Time

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Verification of Veteran's Benefits

State and/or Federal Regulations require us to verify veteran benefits made to the person that has provided authorization below, in order to determine their eligibility for program assistance. Your cooperation in providing the requested information below is most appreciated. A self-addressed return envelope is enclosed, or you may fax to: **(850) 229-7180** or email to: **ship@gulfcounty-fl.gov.**

Authorization:
I hereby authorize the release of requested information. A copy of the executed "Authorization for the Release of Information" is attached which indicates my agreement with the release of information requested for the sole purpose of determining eligibility for program assistance.

_____

Signature of Beneficiary Print Name Date

Address of Beneficiary: _____

_____

Please return information to:

Name: **Naomi L. Lanier** Title: **S.H.I.P. Administrator**
Department: **S.H.I.P.** Phone: **(850) 229-6125**
Address: **1000 Cecil G. Costin Sr., Blvd., Room 311, Port St. Joe, FL 32456**

Complete the Sections below:

Name of Veteran: _____

Address: _____

Claim No._____Date of Birth _____

Service dates: From_____to _____

Benefits paid to_____current benefit amount _____

Original start date:_____this amount will_____increase_____decrease

Date change takes effect:_____new amount$_____

Benefit Type:

_____

Signature of authorized representative:

Printed Name:_____Title: _____

Date:_____Phone: _____

WARNING: 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.

NOTICE REGARDING COLLECTION OF SOCIAL SECURITY NUMBERS
GULF COUNTY SHIP PROGRAM

The following disclosure is being made pursuant to section 119.071(5), Florida Statutes.

Social Security numbers of applicants and household members are requested because this information has been determined to be imperative for the performance of the duties and responsibilities prescribed by law under the Gulf County SHIP Program. This information is not required by state or federal law; however, Social Security numbers are necessary to determine eligibility for program services and specifically for the following purposes:

1. To verify an applicant's identity.
2. To verify household size.
3. To verify household income.
4. To verify household assets.
5. To verify household employment.

A Social Security number collected pursuant to this notice can only be used by the Gulf County SHIP Program, for the purposes specified above.

Nondisclosure except under limited circumstances.
Social security numbers will not be disclosed to others unless required or authorized by Florida law. Section 119.071(5), Florida Statutes, allows disclosure of a person's Social Security number under the following specific, limited circumstances:

- If disclosure is expressly required by federal or Florida law or is necessary for the agency or governmental entity to perform its duties and responsibilities;
- If the individual expressly consents to disclosure in writing;
- If disclosure is made to prevent and combat terrorism pursuant to the U.S. Patriot Act of 2001 or Presidential Executive Order 13224 (blocking property and prohibiting business transactions with persons who commit, threaten to commit, or support terrorism);
- If disclosure is for the purpose of the administration of the Uniform Commercial Code by the office of the Secretary of State.
- If disclosure is requested by a commercial entity for permissible uses under the federal Driver's Privacy Protection Act of 1994, the federal Fair Credit Reporting Act, or the federal Financial Services Modernization Act of 1999 (for example, to verify the accuracy of personal information provided by the individual to the commercial entity; use by an insurer in connection with claims investigation or anti-fraud activities; for use in connection with a credit transaction).

Acknowledgment of Receipt of Notice
I confirm that I have been provided a copy of this notice regarding the collection of my Social Security number and the Social Security numbers of all household occupants as part of the application process for the GULF County SHIP Program.

_____ _____
Date Applicant/s Signature

_____ _____
Date Co-Applicant's Signature