



CRF DISASTER PROGRAM DOCUMENTATION CHECKLIST

Review Eligibility Requirements before continuing. Please provide the information listed below to ensure that your application will be processed in an expedited manner.

PLEASE CHECK ALL BOXES THAT APPLY

- I am a Marion County resident affected COVID-19
- I have had a reduction of income due to COVID-19 (furloughed, loss of employment, reduced hours)
- I can provide a Driver's License (of FL identification card) for ages 18+ in the household
- I have a Social Security Card for all members in the household
- I can provide a copy of Birth Certificates for all household members under 18
- I have all the applicable documents for every household member over 18:
 - 60 Days of Paystubs or supporting documents from employer
 - Social Security Benefits Letter
 - Child Support Income (including current child support court order, documentation from Court House, or letter from Department of Revenue for every child under 18)
 - Ongoing Cash Support from family or friends
 - Other Additional Income: (Unemployment, TANF, Cash Assistance, Self-Employment, etc.)
 - 2018 or 2019 Tax Return
- I have all the applicable documents for every household member over 18:
 - Copy of last 6 months complete bank statements for all Checking Accounts and, if applicable, one last month complete Savings Account
 - Documentation of Proof of Hardship due to COVID (COVID Docs, Employer Letter)
 - Rent (Copy of Lease containing all household members, and w9 from Landlord). Late Notice and/or Demand Letter if applicable
 - Mortgage Statement(s) – (w9 from Mortgage Company). Late Notice and/or Demand Letter if applicable
 - Utilities Bill (Late Notice, Demand Letter, Letter from Utility Company if new service). Check all that apply
 - Electric
 - Water
 - Sewer
 - Gas
 - Cable
 - Internet
 - Phone

To apply for assistance, please go to www.uwmc.org/crf to fill out the application online. You must save or print this document in order to submit this application. Applicant must submit ALL documents together to apply@uwmc.org or call 352-299-6307 to set up an appointment to determine your eligibility.

Incomplete applications will not be accepted.



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 County.
 - b. In the event that the applicant received, receives or is scheduled to receive any Proceeds not previously disclosed to the County the applicant shall notify the County of such Subsequent Proceeds, and the 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 County, any Subsequent DOB Proceeds shall be paid by applicant to the County up to the amount of the Award.
- (2) If no portion of the Award has been expended by the County, any Subsequent DOB Proceeds shall be paid by applicant to the 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 County shall be returned to the applicant, and this Agreement shall terminate.
- (3) If some portion of the Award has been expended by the 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 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 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 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 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 County has recovered an amount equal to the Award, the County will reassign to applicant any rights assigned to the 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

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.

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 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 Statutes.

I/We agree that the County does not have any duty or obligation to assert any defense, exception, or exemption to prevent any or all information given to the 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 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 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.

ELIGIBILITY RELEASE: It is required that you sign this form, which allows the United Way of Marion County and Governmental entities 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

HOUSING INTAKE APPLICATION

Application Number: _____	
Application Received By: _____	Date/Time Application Received: _____
What type of housing assistance are you requesting? Check all that apply	
Rent Mortgage HOA fees Electric Water Gas	
Other (Explain) _____	
1. 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
2. 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

3. ALTERNATE CONTACT NAME _____ **Phone #** _____

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
						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):

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White
<input type="checkbox"/> Black or African American	<input type="checkbox"/> 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.

6. 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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How many household members are affected by COVID-19?

For each Household member affected by COVID-19, provide the following information:

7. First household member affected by COVID-19

Name:

Are they unemployed or underemployed due to COVID-19?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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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 No		
If yes, how much are they receiving monthly \$		
Provide additional information about Hardship:		
Second household member affected by COVID-19		
Name:		
Are they unemployed or underemployed due to COVID-19?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Date the 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:

Property Information

Do you rent or own a pre-1994 mobile or manufactured home?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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Are you past due or delinquent on your rent, mortgage or utilities?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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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
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How many mortgage payments are past due?	Amount Due
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How many months of HOA fees are past due?	Amount Due
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How many months of utilities are past due?	Amount Due
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The following question will require a special review to determine eligibility:

Did you apply for COVID-19 assistance to any other program or organization?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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Explain:

8. Have you received any COVID related assistance? (Duplication of Benefits)	<input type="checkbox"/> Yes (Initials) <input type="checkbox"/> No (Initials)
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Amount Approved?	Amount Received to date:
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List agency providing services	1
	2
	3

If yes, explain the type of assistance you received e.g. Red Cross, United Way, insurance, previous federal or state assistance (CRF, CDBG, CDBG-DR, HOME), etc.	
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(List all Assistance with rent, mortgage, utilities, etc.)

9. 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.)

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

Do you own any other real estate?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If yes, provide address, city and state of property(s):	
What is the tax roll value of the property?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is the current balance owed on the mortgage?	
Do you have income from the property? (rental income)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered yes, provide amount of annual income	\$
Is your primary residence currently in foreclosure?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 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 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.

USE OF SOCIAL SECURITY NUMBERS

1. The use of your social security number is for identification purposes only. Per Florida Statute: **Chapter 119.071 subsections (5) (a) 2.a.b. Fla Stat. 2.**
2. Providing your social security number is voluntary, however refusal to do so may result in a denied application.
3. By signing below you are acknowledging your agreement to produce your social security number.

_____	_____	_____	_____
Applicant Print Name	Social Security Number	Signature	Date
_____	_____	_____	_____
Co-Applicant Print Name	Social Security Number	Signature	Date
_____	_____	_____	_____
Household Member Over 18	Social Security Number	Signature	Date
_____	_____	_____	_____
Household Member Over 18	Social Security Number	Signature	Date
_____	_____	_____	_____
Minor Household Member	Social Security Number	Parent/Guardian Signature	Date
_____	_____	_____	_____
Minor Household Member	Social Security Number	Parent/Guardian Signature	Date
_____	_____	_____	_____
Minor Household Member	Social Security Number	Parent/Guardian Signature	Date

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 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 state and federal guidelines.

I/We authorize the above-referenced County and United Way of Marion County 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

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