



Live United Village
600 N. Highway 17-92, Suite 154
Longwood, FL 32750
(407) 260-9155
www.thesharingcenter.org

Application for Rent, Mortgage, and Utility Assistance

- **PLEASE READ ALL INSTRUCTIONS CAREFULLY.**
- **THE SHARING CENTER CANNOT ACCEPT APPLICATIONS OR OTHER DOCUMENTS VIA EMAIL OR FAX. ALL DOCUMENTS MUST BE PRINTED OR COPIED AND SUBMITTED PHYSICALLY:**
 - **IN PERSON: MONDAY-FRIDAY BETWEEN 9 A.M. AND 12 P.M., OR BETWEEN 1 P.M. AND 4 P.M., TO CLIENT SERVICES IN SUITE 154.**
 - **BY MAIL: ATTN CLIENT SERVICES, 600 N HWY 17-92, SUITE 130, LONGWOOD, FL 32750.**
- **PLEASE DO NOT STAPLE DOCUMENTS TOGETHER. PLEASE DO NOT PROVIDE ORIGINALS. AFTER AN APPLICATION IS FULLY PROCESSED, ALL DOCUMENTS ARE SHREDDED.**
- **APPLICATIONS WILL BE PROCESSED IN THE ORDER THEY ARE SUBMITTED.**

To be eligible for financial assistance, the household **(1)** must live in Seminole County, **(2)** must have experienced an unexpected financial hardship that was outside of the household's control, **(3)** must currently have net income equal to at least 100% of rent/mortgage, utilities, car payment, and car insurance, **(4)** must NOT have received other financial assistance from any agency within the last 12 months, and **(5)** must provide this completed application and ALL of the documents listed below:

1. Release of information form for HSN HMIS, found in the back of the application.
2. Photo identification for ALL adults 18 years or older (driver license, state ID, or passport).
3. Birth certificates for ALL children 18 years or younger.
4. Social security cards for ALL household members. Household members who do not have their SSC may provide a recent tax return, SSA letter, or other document that shows their SSN; household members who do not have an SSN may provide a passport instead.
5. Rental lease AND current ledger (lease must include utility addendums if applicable, must be current, and must be signed by all parties) or most recent monthly mortgage statement.
6. Proof of hardship. (E.g., DEO unemployment documentation, paystubs reflecting a decrease in consistent hours not due to regular fluctuation, employment termination letter, etc.)
7. Proof of ALL household income (earned and unearned) received within the last 90 days.
8. Full copies of the 3 most recent monthly statements for ALL bank/financial accounts owned by any household member(s). Statements must include ALL pages with no information redacted. (E.g., checking/savings, Cash App, Chime, pay cards, Direct Express account from the SSA, etc.)
9. Most recent utility bills (electric, water, and gas), car insurance bill(s), AND car payment bill(s).
10. Recent attendance records for all children 18 or younger attending elementary, middle, or high school in Seminole County (showing the names of the child and their school).

Please note additional documents may be requested by your case manager upon review.



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SHARING CENTER CASE MANAGER USE ONLY	
HMIS #:	Property Appraiser Information:
Date Received:	
Date Received Complete:	
Last Received Financial Assistance:	

Household and Landlord Information

Address:		Rent or Mortgage? <input type="checkbox"/> Rent <input type="checkbox"/> Own (paying mortgage) <input type="checkbox"/> Own (mortgage paid off)	
# of Adults:	Applicant Phone #:	Applicant Email:	
# of Children:			
Property Manager/Landlord/Mortgage Company Name:		Check Payee Name and Mailing Address (leave blank if unsure and cannot get this information):	
Landlord/Property Manager Phone #:			
Landlord/Property Manager Email:		What are you requesting assistance for? (Which bills and for which months?):	

Head of Household

First and Last Name:			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____		
Social Security Number:	Date of Birth:	Age:	Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer:	School:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Multi-racial (3 or more races) or Pacific Islander				



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Additional household members:

First and Last Name:	Relationship to Applicant:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Social Security Number:	Date of Birth:	Age:	Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:	School:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Multi-racial (3 or more races) or Pacific Islander		

First and Last Name:	Relationship to Applicant:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Social Security Number:	Date of Birth:	Age:	Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:	School:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Multi-racial (3 or more races) or Pacific Islander		

First and Last Name:	Relationship to Applicant:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Social Security Number:	Date of Birth:	Age:	Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:	School:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Multi-racial (3 or more races) or Pacific Islander		



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Additional household members:

First and Last Name:	Relationship to Applicant:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Social Security Number:	Date of Birth:	Age:	Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:	School:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all disabilities:	Race (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Multi-racial (3 or more races) or Pacific Islander		

First and Last Name:	Relationship to Applicant:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Social Security Number:	Date of Birth:	Age:	Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:	School:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Multi-racial (3 or more races) or Pacific Islander		

First and Last Name:	Relationship to Applicant:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Social Security Number:	Date of Birth:	Age:	Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:	School:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Multi-racial (3 or more races) or Pacific Islander		



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Sign your initials next to each of the below statements to verify that you have read and understood each statement and that you confirm each statement is true. Failure to initial any of the statements may result in your application being denied.

_____ I live in Seminole County.

_____ I am legally financially responsible for paying my rent/mortgage and utilities (if requesting utility assistance).

_____ I do NOT receive Section 8 or any other housing subsidy.

_____ My household has recently experienced an unexpected financial hardship (i.e., a loss of income or an unexpected expense) that occurred while we lived in Seminole County and was outside of our control. Our financial hardship is documented and verifiable.

_____ If past due bills are paid, my household has enough income to pay all of our monthly bills moving forward (rent/mortgage, utilities, car payment, and car insurance). Our income is documented and verifiable. Income that is no longer being received, undocumented under-the-table income, one-time payments, assistance from family/friends, and prospective income that is estimated to be received but not yet guaranteed cannot be considered.

_____ I have NOT received other financial assistance from The Sharing Center, Seminole County Community Services, or any other agency within the last 12 months.

_____ The maximum amount of financial assistance The Sharing Center can provide is \$2000 in total between rent/mortgage and utilities (and no more than \$500 toward any individual utility bill). If my past due balance is greater than that, I must pay the difference BEFORE financial assistance is granted.

_____ Submitting this application does not guarantee I will receive financial assistance. My household must meet all eligibility requirements, and all requested documents must be provided. In addition, The Sharing Center cannot grant financial assistance if my landlord/property manager will not accept payment from The Sharing Center in the form of a paper check, or if they have filed an official eviction through the Seminole County Clerk of Court as of the date this application is submitted.



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Enter ALL current household income, earned and unearned, that is documented and verifiable. Income that is no longer being received, undocumented under-the-table income, one-time payments, assistance from family/friends, and prospective income that is estimated to be received but not yet guaranteed cannot be considered. New employment that will start soon may be considered if a job offer letter is provided (showing start date and salary). Examples for "Type of Income" include wages, social security, pensions, VA benefits, and food stamps. Enter net income, not gross. If ANY household member 18 years or older does not have income, write that person's name under "Household Member" and write "no income," "N/A," or other indicator under "Type of Income." Documents must be provided to verify all income.

Household Member	Type of Income	Net \$ Amount (per month)	Date Started Receiving

Enter all household monthly expenses below. Bills must be provided to verify all expenses.

Monthly Expenses	\$ Amount (per month)
Rent or Mortgage	
Electric	
Water & Sewer	
Natural Gas	
Car Payment (total for all household members)	
Car Insurance (total for all household members)	

TOTAL INCOME: _____ TOTAL EXPENSES: _____



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Disclosure Statement:

By signing below, I confirm that the information I have provided in this application is complete and true to the best of my knowledge. I understand that full disclosure of all the information requested by The Sharing Center is a mandatory requirement for financial assistance and that if any information listed in this application is found to be untrue, my household will be immediately disqualified. I understand that if I omit information, I will be disqualified.

Applicant Signature

Date

Other Household Member (18 years or older) Signature

Date

Other Household Member (18 years or older) Signature

Date

Other Household Member (18 years or older) Signature

Date



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Consent for Release of Confidential Information

I hereby authorize The Sharing Center to disclose and/or obtain information relevant to my participation in The Sharing Center programs to others, including but not limited to other private social service agencies, governmental units, landlords or their representatives, medical providers, past and present employers, utility companies, religious organizations, banks and other financial institutions, etc. for the purpose of verifying information provided as part of determining eligibility for assistance.

I understand that this information is confidential and protected by federal regulations, which prohibit further disclosure without specific written authorization of the undersigned or as otherwise permitted by such regulations. If this information is further disclosed by the recipient to individual organizations not subject to federal privacy regulations it may no longer be protected.

I understand that this authorization may be revoked upon written notice to The Sharing Center except to the extent that action has already been taken on this authorization. This release will automatically expire one year from client's signature date.

Client Printed Name and Signature

Date

Witness Printed Name and Signature

Date



*Continuum of Care FL-507 | Homeless Services Network of Central Florida
Client Informed Consent & Authorization for Release of Information in HMIS*

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions or desire any further information regarding this form, please contact the CoC System Administrators via the CoC HMIS Help Desk by submitting a ticket on our website (<https://hmiscfl.org>).

1. In order to best serve your needs, to develop meaningful case management plans, to determine your continuing eligibility for services, and to document provision of services, the Continuum of Care (CoC) needs to exchange, share, and/or release data, information or records they may collect about you with other CoC Member Agencies.
2. The information contained in your HMIS records with any Agency is considered confidential and privileged and cannot be exchanged, shared and/or released without your express and informed consent, except where otherwise authorized by law. Please understand that access to shelter, housing and services is available without your consent for the release of the information. However, your consent to share information with other service agencies is a critical component of our community's ability to provide the most effective services and housing possible.
3. I understand that:
 - a) CoC Member Agencies may not refuse to serve me simply because I do not want my information shared with other service agencies.
 - b) Agencies that join the CoC HMIS after I sign this consent/authorization also will have access to the personal information that I authorize for data sharing. All CoC Agencies must make reasonable accommodations to allow me to view the updated list of CoC HMIS Partner Agencies.
 - c) I have the right to inspect, copy, and request all records maintained by an Agency relating to the provision of services provided by an Agency to me and to receive a copy of this form unless specifically denied under federal or state law.
 - d) My records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise authorized by law.
 - e) This release is valid for three years from the date I sign this document. I may revoke this authorization at any time by written request.
 - f) Any cancellation of this consent will not retroactively change information that has already been disclosed or actions already taken under your previous authorization.

I give my consent to the exchange of my information, and that of my minor children (if applicable, as listed below), via the CoC HMIS:

Yes No

I have read this document or it was read and/or explained to me and I fully understand and agree with the terms of this document.

Name and Signature of Client		Name and Signature of Witness	
_____	_____	_____	_____
(Print)		(Print)	
_____	_____	_____	_____
(Signature)	(Date)	(Signature)	(Date)

Minor Children (if any):

Client Name: _____ DOB: _____ Last 4 digits of SSN: _____

Client Name: _____ DOB: _____ Last 4 digits of SSN: _____

Client Name: _____ DOB: _____ Last 4 digits of SSN: _____