



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

## Application for Rent, Mortgage, and Utility Assistance

**PLEASE READ ALL INSTRUCTIONS CAREFULLY. FAILURE TO FOLLOW INSTRUCTIONS OR FAILURE TO PROVIDE ALL REQUIRED INFORMATION MAY RESULT IN YOUR APPLICATION BEING DENIED.**

- **\*\*PLEASE NOTE\*\* The Sharing Center cannot accept applications or documents via email or fax. Printing services are not available at The Sharing Center. All documents must be printed or copied beforehand and submitted physically:**
  - **IN PERSON: Monday–Friday (excluding observed holidays), 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. Submitted documents will not be returned.**
- **Applications will be processed in the order they are submitted.**

To be eligible for financial assistance, the household must **(1)** meet all basic requirements (listed on page 2), **(2)** have experienced an eligible financial hardship (see details on pages 3-5), **(3)** have sufficient income to pay all monthly bills moving forward (see details on page 6), and **(4)** provide this completed application and all documents listed below\*:

1. Photo identification for all adults 18 years or older (driver license, state ID, etc.).
2. Birth certificates for all minors 18 years or younger.
3. Social security cards for all household members (or a recent tax return showing their full SSN).
4. 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.
5. Verification of an eligible financial hardship (see details on pages 3-5).
6. Verification of all household income received within the last 90 days (see details on page 6).
7. Full copies of the three (3) most recent monthly statements for all bank/financial accounts owned by any household member. (Examples: checking/savings, Cash App, Chime, pay cards, Direct Express account, etc.) Statements must include all pages (even if some pages do not contain relevant information, such as a page stating “this page intentionally left blank”).
8. Most recent utility bills (electric, water, and gas), car insurance bill(s), AND car payment bill(s).
9. Verification that an individual listed on your lease or mortgage statement does not live with you: (1) a recent lease, mortgage statement, or utility bill in their name, (2) written verification from your landlord/property manager, (3) a divorce decree, (4) an injunction for protection, OR (5) a death certificate. If you cannot provide any of these documents, then the individual must be considered a household member and all other documents for them must be provided.

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

**NOTE: Your application may be withdrawn without interview if at least three of the above listed documents are missing upon submission of the application. To be re-considered for assistance, you will need to submit a new application with all required documentation.**

**NOTE: Documents will be corroborated. If any document is found to be fabricated or altered, it will constitute an act of fraud, and all household members will be indefinitely barred from services.**

Ensure all pages of the application have the latest revision date at the bottom. The latest version of the application can be found at [TheSharingCenter.org/familiesin crisis](http://TheSharingCenter.org/familiesin crisis). Older versions will not be accepted.



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<b>SHARING CENTER CASE MANAGER USE ONLY</b>	
HMIS #: _____	Date and Time Received: _____
Last Received Financial Assistance: _____	_____ / _____ / _____
Other Notes: _____	_____ : _____ AM / PM

**Basic Household Information**

Address: _____	Do You Rent or Own? <input type="checkbox"/> Rent <input type="checkbox"/> Own (paying mortgage) <input type="checkbox"/> Own (mortgage paid off)
Applicant Phone #:	How long have you lived at your current residence?
Applicant Email:	What are you requesting assistance for? <i>(Please note assistance is not provided for bills accrued within the first 30 days after move-in, deposits, moving costs, hotel costs, rent from subleasing, or any other bills except the below listed.)</i>
Landlord/Property Manager/Mortgage Company Name:	<input type="checkbox"/> Rent <input type="checkbox"/> Mortgage <input type="checkbox"/> Electric utility <input type="checkbox"/> Water utility <input type="checkbox"/> Natural gas utility
Landlord/Property Manager Phone #:	For which month(s)?
Landlord/Property Manager Email:	<input type="checkbox"/> January <input type="checkbox"/> February <input type="checkbox"/> March <input type="checkbox"/> April <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> August <input type="checkbox"/> September <input type="checkbox"/> October <input type="checkbox"/> November <input type="checkbox"/> December

**Head of Household / Applicant**

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: _____			
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all: _____	Race/Ethnicity (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other: _____		



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**Additional Household Members (if applicable):**

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:		Relationship to Applicant:	
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race/Ethnicity (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other: _____		

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:		Relationship to Applicant:	
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race/Ethnicity (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other: _____		

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:		Relationship to Applicant:	
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race/Ethnicity (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other: _____		

1 CONT.  
 (ADDITIONAL HOUSEHOLD MEMBERS)

\*Revised August 2024\*



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**Additional Household Members (if applicable):**

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:		Relationship to Applicant:	
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race/Ethnicity (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other: _____		

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:		Relationship to Applicant:	
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race/Ethnicity (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other: _____		

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:		Relationship to Applicant:	
Physical or mental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list all:	Race/Ethnicity (choose all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other: _____		

1 CONT.  
 (ADDITIONAL HOUSEHOLD MEMBERS)

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**To qualify for assistance, the household must meet all basic eligibility requirements listed below. 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 will result in your application being denied.**

\_\_\_\_\_ I live in Seminole County, and I have lived at my current residence for at least 30 days.

\_\_\_\_\_ I am legally financially responsible for paying my rent/mortgage and utilities (if requesting utility assistance), and I am not subleasing.

\_\_\_\_\_ My household does NOT receive Section 8 or any other monthly housing subsidy.

\_\_\_\_\_ My household has NOT received other financial assistance from The Sharing Center, Seminole County Community Services, or any other agency within the last 12 months.

\_\_\_\_\_ My household has recently experienced an eligible financial hardship (see pages 3-5 for more details about the qualifications of an eligible financial hardship for this program).

\_\_\_\_\_ If past due bills are paid, my household has enough income to pay all monthly bills moving forward (see details on page 6). This income is documented and verifiable. The following are NOT considered income: 1) income that is no longer being received, 2) undocumented under-the-table income, 3) one-time payments, 4) assistance from family/friends, and 5) prospective income that is estimated to be received but not yet guaranteed.

**Additional disclaimers are listed below. Sign your initials next to each of the below statements to verify that you have read and understood each. Failure to initial any of the statements will result in your application being denied.**

\_\_\_\_\_ My application may be withdrawn if my arrearages are too significant. The maximum amount of assistance The Sharing Center can provide varies based on the availability of funds. I may have to make a partial payment toward my past due balance BEFORE The Sharing Center can assist.

\_\_\_\_\_ If at least three of the required documents (listed on the front page of the application) are not provided upon submission of my application, it may be withdrawn without interview or follow-up. 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.

\_\_\_\_\_ The Sharing Center cannot provide rental 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 reviewed and processed by a case manager.



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**PLEASE NOTE YOUR APPLICATION MAY BE WITHDRAWN WITHOUT INTERVIEW BASED ON THE INFORMATION PROVIDED ON PAGES 3-5, OR IF YOU DO NOT PROVIDE ALL REQUESTED INFORMATION OR THE LISTED REQUIRED DOCUMENTS.**

An **eligible financial hardship** is a loss of income, or an extra expense that the household has paid, that meets all seven of the below listed criteria. **Sign your initials next to each of the criteria to verify that each one is true.** Any hardship that fails to meet one or more of the following criteria is not eligible.

**(1) \_\_\_\_\_ The hardship occurred while the household lived in Seminole County.**

**(2) \_\_\_\_\_ The hardship was outside of the household's control and was not a result of a household member's actions or neglect of responsibility.**

**ELIGIBLE EXAMPLES:** Laid off due to company downsizing or not meeting performance expectations.

**INELIGIBLE EXAMPLES:** Voluntarily quitting one's job. Termination due to violating company policy, tardiness, or unprofessionalism. Reduction of social security payments due to failing to report all household income. Expenses related to tolls or traffic tickets.

**(3) \_\_\_\_\_ The hardship was unexpected and unforeseeable.**

**ELIGIBLE EXAMPLES:** Leave of absence due to unexpected medical reasons or bereavement.

**INELIGIBLE EXAMPLES:** Expected loss of employment (e.g., job contract reached its known end date). Loss of hours due to a job's typical slow season, such as summertime for school employees. Loss of hours due to weather (e.g., rain) unless classified as a natural disaster. A recurring or normal fluctuation of hours. Maternity leave. Expected lapse or termination of monthly payments (e.g., termination of child support due to child turning 18).

**(4) \_\_\_\_\_ The hardship occurred within the last sixty (60) days. Prior to that, the household was self-sufficient and paying all monthly bills on time.**

**(5) \_\_\_\_\_ The hardship reasonably explains why the requested assistance is needed.**

**NOTE:** In general, the amount of financial assistance provided will not exceed the hardship incurred. (Examples: If the household lost \$800 of its regular monthly income due to medical leave, the maximum assistance will be \$800. If the household paid \$650 toward necessary vehicle repairs, the maximum assistance will be \$650.) Assistance will not be provided if the household had sufficient income and/or available funds in accounts to pay bills despite the hardship. Assistance will not be provided for bills that accrued prior to when the hardship occurred (e.g., assistance will not be provided for March's rent, due on March 1st, if the actual loss of income occurred in March).

**(6) \_\_\_\_\_ The hardship was temporary and is now resolved. The household will have sufficient income (as defined on page 6) to pay all bills moving forward.**

**ELIGIBLE EXAMPLES:** Household member lost their job but has started a new job (or will start a new job in the next 14 days). Household member was on a medical leave of absence but has returned to work (or will return to work in the next 14 days). Household member was a homemaker prior to divorce but has since secured their own income.

**INELIGIBLE EXAMPLES:** Household member lost their job and is still unemployed/job-searching/interviewing. Regarding a medical leave of absence, return-to-work date is unknown or more than 14 days in the future.

**(7) \_\_\_\_\_ It is documented and verifiable that the hardship meets all previous criteria.**



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**Please see below for more information about the guidelines regarding a financial hardship. Following that, on this page and the next page, you will have the opportunity to provide details regarding your household's hardship.**

**INELIGIBLE HARDSHIPS INCLUDE (but are not limited to):**

- **INELIGIBLE:** An increase in rent or other increased cost of living, including a higher-than-usual utility bill.
- **INELIGIBLE:** The repayment of loans, credit cards, interest, or other debts.
- **INELIGIBLE:** Hardships that are expected to continue to impact household's ability to pay bills moving forward. (Examples: The household just doesn't make enough money to pay bills. A household member lost their job but has not yet secured other income.) The hardship must be resolved to qualify for assistance.
- **INELIGIBLE:** A reduction of income that is not guaranteed, such as overtime, tips, sales, or commission.
- **INELIGIBLE:** Expenses paid by credit card, even if a household member later paid off the credit card. Expenses paid by a third party, even if a household member later paid them back. Expenses paid by cash or other means that cannot be traced to a household member. Expenses that have not been paid.

**NOTE:** In general, the amount of financial assistance provided will not exceed the hardship incurred. (Examples: If the household lost \$800 of its regular monthly income due to medical leave, the maximum assistance will be \$800. If the household paid \$650 toward necessary vehicle repairs, the maximum assistance will be \$650.) Assistance will not be provided if the household had sufficient income and/or available funds in accounts to pay bills despite the hardship.

**NOTE:** Assistance will be considered for the month following when the hardship occurred, if all arrearages prior to that have been paid. Assistance will not be provided for bills that accrued prior to when the hardship occurred (e.g., assistance will not be provided for March's rent, due on March 1st, if the actual loss of income occurred in March).

**Please check the appropriate boxes below and fill in the corresponding blanks.**

**1. My household had an unexpected extra expense.** (check yes or no)

**Yes** (check all that apply below, and fill in corresponding blanks)  **No** (skip to next page)

▶  **Unexpected and necessary car or home repairs.**

Date(s) of payment(s): \_\_\_\_\_ Total amount paid: \_\_\_\_\_

Form of payment(s) (which bank account, if applicable): \_\_\_\_\_

**NOT ELIGIBLE:** Routine maintenance (e.g., oil change, tire change, battery replacement, etc.). Expenses paid by credit card, cash, or a third party. Unpaid expenses.

**REQUIRED DOCUMENTS:** Receipt(s)/invoice(s) from repair shop or contractor verifying expenses paid.

▶  **Expenses related to the death of a family member, paid to the funeral home.**

Date(s) of payment(s): \_\_\_\_\_ Total amount paid: \_\_\_\_\_

Form of payment(s) (which bank account, if applicable): \_\_\_\_\_

**NOT ELIGIBLE:** Travel expenses. Expenses paid by credit card, cash, or a third party. Unpaid expenses.

**REQUIRED DOCUMENTS:** Documentation verifying death of family member and their relation to household member AND receipt(s)/invoice(s) from funeral home verifying expenses paid.

▶  **Expenses related to taking guardianship of a minor child by court order.**

Name of minor child: \_\_\_\_\_ Date guardianship began: \_\_\_\_\_

Date(s) of payment(s): \_\_\_\_\_ Total amount paid: \_\_\_\_\_

Form of payment(s) (which bank account, if applicable): \_\_\_\_\_

**NOT ELIGIBLE:** Expenses paid by credit card, cash, or a third party. Unpaid expenses. Hardship is expected to continue to affect sustainability moving forward.

**REQUIRED DOCUMENTS:** Court order documents AND receipt(s) verifying expenses paid related to guardianship.

▶  **Other.** Briefly explain: \_\_\_\_\_



the  
**Sharing**  
center

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## 2. My household had an unexpected loss of income. (check yes or no)

**Yes** (check all that apply below, and fill in corresponding blanks)  **No** (skip to next page)

➔  **Loss of employment.**

Date of loss of employment: \_\_\_\_\_ Date new employment began/begins: \_\_\_\_\_

How long did you have that job: \_\_\_\_\_ Reason for loss of job: \_\_\_\_\_

**NOT ELIGIBLE:** Loss of employment due to one's own actions, including violating company policy or voluntarily quitting. Expected loss of employment (e.g., job contract reached its known end date). New employment start date is 14 days or more in the future. Hardship is expected to continue to affect sustainability moving forward.

**REQUIRED DOCUMENTS:** Termination letter from prior employer AND copy of last paystub received, OR documentation from the DEO showing eligible unemployment income.

➔  **Unexpected reduction of hours.**

Dates of reduced hours: From \_\_\_\_\_ to \_\_\_\_\_ Reason: \_\_\_\_\_

**NOT ELIGIBLE:** Expected loss of hours (e.g., a job's typical slow season, such as summertime for school employees). A recurring or normal fluctuation of hours. A reduction of overtime hours. Voluntary reduction of hours (e.g., vacation). Loss of hours due to lack of transportation. Loss of hours due to weather (e.g., rain) unless classified as a natural disaster. Hardship is expected to continue to affect sustainability moving forward.

**REQUIRED DOCUMENTS:** Documentation from employer verifying reason for and duration of loss of hours.

➔  **Out of work (unpaid or reduced pay) due to medical reasons.**

Dates out of work: \_\_\_\_\_ Reason: \_\_\_\_\_

**NOT ELIGIBLE:** Maternity leave. Return-to-work date is unknown or 14 days or more in the future. Hardship is expected to continue to affect sustainability moving forward.

**REQUIRED DOCUMENTS:** Documentation from doctor or employer verifying medical leave of absence.

➔  **Out of work (unpaid or reduced pay) due to bereavement leave.**

Dates out of work: From \_\_\_\_\_ to \_\_\_\_\_

**REQUIRED DOCUMENTS:** Documentation verifying death AND documentation verifying bereavement leave.

➔  **Unexpected lapse or reduction in otherwise consistent child support payments, social security, VA benefits, pension, etc.**

Date of lapse or reduction: \_\_\_\_\_ Reason: \_\_\_\_\_

**NOT ELIGIBLE:** Expected lapse or termination of payments (e.g., termination of child support due to child turning 18). Lapse or reduction due to household member's own actions (e.g., reduced social security payments due to not reporting all income). Hardship is expected to continue to affect sustainability moving forward.

**REQUIRED DOCUMENTS:** Documentation from the agency indicating lapse in payment and the reason for lapse.

➔  **Death or divorce of household member listed on the lease/mortgage statement.**

Date of loss of household member: \_\_\_\_\_ Reason for loss: \_\_\_\_\_

**NOT ELIGIBLE:** Household member moving out for any reason other than divorce, including a separation from a significant other by means other than divorce. Household member did not have income and/or was not listed on lease/mortgage at the time of loss. Hardship is expected to continue to affect sustainability moving forward.

**REQUIRED DOCUMENTS:** Documentation verifying loss of household member (e.g., death certificate or divorce decree) AND documentation verifying their income prior to loss of household member.

➔  **Household member's money was stolen and not yet recovered.**

Date of incident: \_\_\_\_\_ Total amount stolen: \_\_\_\_\_

**REQUIRED DOCUMENTS:** Police report describing incident and the amounts that were stolen.

➔  **Other.** Briefly explain: \_\_\_\_\_





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**In the table below, enter all current household income that is documented and verifiable.** The following are NOT considered income: **(1)** income that is no longer being received, **(2)** undocumented under-the-table income, **(3)** one-time payments, **(4)** assistance from family/friends, and **(5)** prospective income that is estimated to be received but not yet guaranteed. If any household member 18 years or older does not have any 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 received within the last 90 days. Bank statements alone are not sufficient.** Examples: All paystubs received within the last 90 days (13 paystubs if paid weekly, 7 paystubs if paid bi-weekly, etc.), most recent annual benefit verification letter if receiving social security benefits, a printout from the Department of Revenue showing all child support payments received within the last 90 days, etc. New employment that will start soon (within 14 days) may be considered if a job offer letter is provided, showing start date and salary.

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

**NOTE:** To qualify for assistance, the household must have sufficient income to pay all monthly bills (listed below) moving forward. For example, if assistance is provided for January’s bills, the household must prove they can pay all bills in February (and moving forward). This income must be documented and verifiable. **If the household has zero income, or insufficient income to pay all monthly bills moving forward, this application will be denied.**

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

Monthly Expenses	Cost Per Month	Total Amount Currently Past Due
Rent or Mortgage	\$	\$
Electric Utility	\$	\$
Water & Sewer Utility	\$	\$
Natural Gas Utility	\$	\$
Car Payment (for all household members)	\$	\$
Car Insurance (for all household members)	\$	\$

TOTAL INCOME: \_\_\_\_\_ TOTAL EXPENSES: \_\_\_\_\_



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## **Disclosure Statement Regarding Falsifying Information**

By signing below, I confirm that the information I have provided in this application, including any documentation, is complete and true to the best of my knowledge. If additional information is requested of me, I will provide the requested information, 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.

I understand that if I omit information, this application may be withdrawn.

I understand that knowingly providing false or misleading information, or knowingly providing fabricated or altered documentation, is an act of fraud. If any fraudulent information or documentation is discovered, this application will be withdrawn and all members of my household and any other persons believed to be involved in falsifying information will be indefinitely barred from receiving services from The Sharing Center.

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Applicant Printed Name and Signature

---

Date

---

Witness Printed Name and 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, government agencies, 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.

\_\_\_\_\_  
Applicant 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: \_\_\_\_\_