

HURRICANE HOUSING RECOVERY PROGRAM (HHRP) APPLICATION

PHASE III

OWNER-OCCUPIED REHABILITATION ASSISTANCE

**1 - ALL OCCUPANTS, PROVIDE A  
COPY OF ISSUED DRIVERS LICENSE OR  
FLORIDA IDENTIFICATION CARD**

**2 - PROVIDE COPY OF  
CURRENT SOCIAL SECURITY  
AWARD LETTER(S), IF  
APPLICABLE**

HURRICANE HOUSING RECOVERY PROGRAM (HHRP) APPLICATION

OWNER-OCCUPIED REHABILITATION ASSISTANCE

**3 - PROVIDE CURRENT COPY  
OF FEDERAL INCOME TAX  
RETURN, IF REQUIRED**

HURRICANE HOUSING RECOVERY PROGRAM (HHRP) APPLICATION

OWNER-OCCUPIED REHABILITATION ASSISTANCE

# **4 - PROVIDE COPY OF DEED, IF APPLICABLE**

**5 - PROVIDE COPY OF  
PAID/CURRENT TAX RECORD,  
IF APPLICABLE**

# **6 - EMPLOYMENT, BANKING & INCOME INFORMATION**

- Past six (6) months of **EMPLOYMENT PAYROLL** account statements, if applicable, and;
- Past six (6) months of **CHECKING** account statements, if applicable, and;
- One (1) month, **CURRENT MONTH**, of **SAVINGS** account information, if applicable, and;
- Any other income related statements, i.e., monthly Federal, State retirement account(s), disability, court settlement(s), alimony, child support, etc., if applicable

**HURRICANE HOUSING RECOVERY PROGRAM (HHRP) APPLICATION**

OWNER-OCCUPIED REHABILITATION

ANNUAL INCOME: \$ \_\_\_\_\_

INCOME CATEGORY (VL, LI, MI): \_\_\_\_\_

GENERAL INFORMATION	APPLICANT	CO-APPLICANT
FULL NAME:		
E-MAIL ADDRESS:		
DATE OF BIRTH/AGE:	/	/
STREET ADDRESS:		
MAILING ADDRESS:		
STATE/CITY/ZIP CODE:		
PHONE NUMBER:		

**OTHER HOUSEHOLD MEMBERS:**

NAME(S)	DATE OF BIRTH/AGE	RELATIONSHIP TO APPLICANT
	/	
	/	
	/	
	/	
	/	

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

Does the 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.): \$ _____	

**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.)**

	<u>Name</u>	<u>Type of Income</u>	<u>Gross Annual Amount</u>
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.)**

	<u>Type of Asset</u>	<u>Asset Value</u>	<u>Bank/Account #</u>	<u>Annual Asset Income</u>
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.)**

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

**Ethnicity/Special Needs Information (for reporting purposes only, please check all that apply for Head of Household Only):**

Black: \_\_\_\_\_ Disabled or Disabled Minor: \_\_\_\_\_  
 White: \_\_\_\_\_ Elderly (62 or older): \_\_\_\_\_  
 Hispanic: \_\_\_\_\_ Homeless: \_\_\_\_\_  
 Asian/Pacific Islander: \_\_\_\_\_ Special Needs: \_\_\_\_\_  
 Native American: \_\_\_\_\_ Other: \_\_\_\_\_  
 Farmworker: \_\_\_\_\_

**NOTICE REGARDING COLLECTION OF SOCIAL SECURITY NUMBERS  
GULF COUNTY HHRP 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 HHRP 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 HHRP 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 HHRP Program.

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Signature of Applicant	Printed Name	Date
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Signature of Co-Applicant	Printed Name	Date
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**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

\_\_\_\_\_, the undersigned, hereby authorize \_\_\_\_\_ to release without liability, information regarding my employment, income, and/or assets to **Gulf County HHRP Program**, for the purposes of verifying information provided as part of determining eligibility for assistance under the **HHRP 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	Alimony/Child Support Providers	Banks, Financial or
Retirement Institutions	Social Security Administration	State Unemployment
Agency	Veteran's Administration	
Welfare Agency	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.

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Signature of Applicant	Printed Name	Date
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Signature of Co-Applicant	Printed Name	Date
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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 VERBAL RELEASE OF PERSONAL INFORMATION

APPLICANT'S INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

-----BELOW COMPLETED BY MANAGER/AGENT(S)-----

TYPE OF ASSISTANCE: Please indicate which program applies

Purchase Assistance: \_\_\_\_\_

Rehabilitation: \_\_\_\_\_

Emergency Repair: \_\_\_\_\_

TYPE OF INFORMATION BEING VERIFIED:

Employment: \_\_\_\_\_

Household: \_\_\_\_\_

Assets: \_\_\_\_\_

Other: \_\_\_\_\_

Name of Entity/Agency being Contacted: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Individual Contacted: \_\_\_\_\_ Title: \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WARNING: Florida Statute 817 provides that willful false statements or m misrepresentation concerning income, asset or misrepresentation concerning income, assets or liability information relating to financial conditions is a misdemeanor of the first degree, punishable by fines and imprisonment provide under Statutes 775.082 or 775.83.

**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.

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Signature of Applicant	Printed Name	Date
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Signature of Co-Applicant	Printed Name	Date
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***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 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 Printed Name Date

Signature of Co-Applicant Printed 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:

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 ASSET INCOME

(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 Printed Name Date
Signature of Co-Applicant Printed 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.

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@gulfcountry-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 Printed Name Date

Signature of Co-Applicant Printed 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

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 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 : (850) 229-7180 or email to: ship@gulfcountry-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 Printed Name Date

Signature of Co-Applicant Printed 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 Name(s): \_\_\_\_\_

Amount of Support: \$ \_\_\_\_\_ Weekly \$ \_\_\_\_\_ Monthly \$ \_\_\_\_\_ Yearly

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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 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.

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Signature of Applicant	Printed Name	Date
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Signature of Co-Applicant	Printed Name	Date
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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 Section 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.

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 Printed Name Date

Signature of Co-Applicant Printed 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:

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.

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 Veteran or Beneficiary Print Name Date

Address of Veteran or 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.

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 Printed Name Date

Signature of Co-Applicant Printed 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:

Table with 4 columns: Category, Amount (\$), Category, Amount (\$). Rows include Interest on Loans, Rent, Wages/Salaries, Federal Withholding Tax, FICA, Other, Costs of goods/materials, Utilities, Employee Contributions, State Withholding Tax, Sales Tax, Other.

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

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.

# Duplication of Benefits Affidavit

<b>OTHER ASSISTANCE RECEIVED:</b> - Assistance provided under the SHIP Program for disaster may not exceed a household's unmet needs. List all other sources of financial or housing assistance received (local, state, federal, and private sources).		
Did you register with FEMA or other disaster related assistance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you applied for any event related assistance from any source (local, state, federal, private)? If yes, proceed with this section.		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>A. FEMA</u></b>		
Have you received any disaster related assistance from FEMA?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Amount Approved?		Amount Received to date:
What is your FEMA Registration No.(s)?		1
		2
		3
<b><u>B. Small Business Administration (SBA)</u></b>		
Have you received any event-related assistance from the SBA?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Amount Approved?		Amount Received to date:
What is your SBA Application No.(s)?		1
		2
		3
What is your SBA Loan No.(s)?		1
		2
What is the status of your SBA Loan, e.g. paying as agreed, did not use, etc.		
<b><u>C. Other Information Needed</u></b>		
Did you receive any other assistance due to disaster?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain the type of assistance you received e.g. Red Cross, United Way, previous federal or state assistance (SHIP, CDBG, CDBG-DR, HOME, INSURANCE SETTLEMENT(S), etc.		

Recipient Statement: The information on this form is to be used to determine eligibility. I/we certify that the statements are true and complete to the best of my/our knowledge and belief under penalty of perjury. **WARNING:** Florida Statute 817 provides that willful false statements or misrepresentation concerning income and assets or liabilities relating to financial condition is a misdemeanor of the first degree.

\_\_\_\_\_  
Print Name (head of Household)

\_\_\_\_\_  
Signature (head of Household)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name (Co-head of Household), if applicable

\_\_\_\_\_  
Signature (head of Household)

\_\_\_\_\_  
Date

21.5.23

## CHAPTER 119 PUBLIC RECORDS DISCLOSURE AND ACKNOWLEDGMENT

Household members understand that all documents provided under the application for housing assistance are subject to Chapter 119 of Florida's public records laws. Information provided by you that is not protected by Florida Statutes can be requested by any individual for their review and/or use. This is without regard to whether you qualify for assistance under the program(s) for which you are applying.

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

Furthermore, by signing below, I/We agree that the local government has no obligation nor duty to provide me/us with notice that a public records request has been made.

\_\_\_\_\_  
Owner/Applicant's Signature/Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Owner/Applicant's Signature/Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Household member Signature/Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Household member Signature/Print Name

\_\_\_\_\_  
Date



HHRP PROGRAM APPLICATION STATEMENT

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.

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Signature of Applicant	Printed Name	Date
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Signature of Co-Applicant	Printed Name	Date
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Signature of Household Member (over 18)	Printed Name	Date
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Signature of Household Member (over 18)	Printed Name	Date
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Signature of Household Member (over 18)	Printed Name	Date
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Signature of Household Member (over 18)	Printed Name	Date
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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.