

WINTER HAVEN SHIP PROGRAM
APPLICATION FOR ASSISTANCE

DATE: _____

HOME PHONE# _____

WORK PHONE# _____

APPLICANT GENERAL INFORMATION

Applicant Name _____ Soc. Sec. # _____

D.O.B. ___/___/___

Street Address: _____

City, State and Zip Code: _____

Phone _____ Alternate Phone (Cell/Other) _____

Email _____

Check One: Single Married Divorced Widow

Type of Assistance Requested

Emergency Repair

Rehabilitation

Briefly state the nature of the repairs below on pages 5 and/or 6, or on a separate sheet of paper. Also include a copy of the most recent property appraiser home tax statement.

ALL OF THE FOLLOWING INFORMATION WILL BE VERIFIED, PLEASE PROVIDE THE CORRECT ADDRESSES.

MAILING ADDRESS: _____

CITY _____ **STATE** _____ **ZIP** _____

STREET ADDRESS: _____

CITY _____ **STATE** _____ **ZIP** _____

How long have you lived at the present address? _____

Do you: Own Other



MEMBERS OF HOUSEHOLD TO INCLUDE:

(Applicant, individual, family, or group of individuals living together in the house).

Other Household Members/Dependents living in the home (under 18 years of age or legally disabled/dependent with proof):

HOUSEHOLD COMPOSITION:

(LIST EVERY PERSON THAT IS CURRENTLY LIVING IN YOUR HOME)

	NAME	RELATIONSHIP	AGE	DATE OF BIRTH	RACE (Caucasian, Black, Hispanic, Asian, Native American, Other)
1					
2					
3					
4					
5					
6					
7					
8					

Disability Status (Please list any household member(s) who has a developmental disability or other handicap/special need.)

*Note: Any applicant or HH member claiming disability must complete this section. If this section is left incomplete the applicant or HH member may not be assumed automatically disabled by the individual(s) reviewing the application. **Only** the applicant may complete this section.*

1.
2.

APPLICANT

List present employer first and go back two years from Date of Application

Date of Employment: Beginning _____ thru _____

Name of Employer: _____ Phone Number: _____

Address of Employer: _____

City and State: _____

Title/Type of Work: _____

Rate of Pay: _____ Hours per Week: _____

Reason for Change: _____

Date of Employment: Beginning _____ thru _____

Name of Employer: _____ Phone Number: _____

Address of Employer: _____

City and State: _____

Title/Type of Work: _____

Rate of Pay: _____ Hours per Week: _____

Reason for Change: _____

Date of Employment: Beginning _____ thru _____

Name of Employer: _____ Phone Number: _____

Address of Employer: _____

City and State: _____

Title/Type of Work: _____

Rate of Pay: _____ Hours per Week: _____

Reason for Change: _____

If more than one form is required because there is more than one household member over age 18, please use a photocopy of the following pages.

CO-APPLICANT and/or HOUSEHOLD MEMBER 18 YEARS OF AGE OR OLDER:

List present employer first and go back two years from Date of Application

Date of Employment: Beginning _____ thru _____

Name of Employer: _____ Phone Number: _____

Address of Employer: _____

City and State: _____

Title/Type of Work: _____

Rate of Pay: _____ Hours per Week: _____

Reason for Change: _____

Date of Employment: Beginning _____ thru _____

Name of Employer: _____ Phone Number: _____

Address of Employer: _____

City and State : _____

Title/Type of Work: _____

Rate of Pay: _____ Hours per Week: _____

Reason for Change: _____

Date of Employment: Beginning _____ thru _____

Name of Employer: _____ Phone Number: _____

Address of Employer: _____

City and State: _____

Title/Type of Work: _____

Rate of Pay: _____ Hours per Week: _____

Reason for Change: _____

APPLICANT

Bank Accounts:

Name and Address of Bank: _____ Phone Number: _____

Checking Account Number: _____

Savings Account Number: _____

Other Account Info: _____

Name and Address of Bank: _____ Phone Number: _____

Checking Account Number: _____

Savings Account Number: _____

Other Account Info: _____

CO-APPLICANT and/or HOUSHOLD MEMBER 18 YEARS OF AGE OR OVER:

Bank Accounts:

Name and Address of Bank: _____ Phone Number: _____

Checking Account Number: _____

Savings Account Number: _____

Other Account Info: _____

Name and Address of Bank: _____ Phone Number: _____

Checking Account Number: _____

Savings Account Number: _____

Other Account Info: _____

CASH HOUSEHOLD INCOME SUMMARY:

Applicant

2024 Estimated Earnings _____

Co-Applicant's/Household Members 18 years of Age or Over

2024 Estimated Earnings _____

Does anyone in the household receive any of the following sources of income (please provide monthly amount):

- _____ Interest and/or Dividends
- _____ Net Income from Business (Please, include a quarterly loss and profit statement and an affidavit of anticipated net income for the next twelve months.)
- _____ Rental Income (Please provide the property tax statement and indicate if there is a mortgage on the property.)
- _____ Social Security, Pensions, Retirement Funds
- _____ Unemployment Benefits, Workers Compensation, etc.
- _____ Alimony, Child Support (Please, include a copy of your divorce decree'.)
- _____ Welfare Payments (Please include your case worker's name and phone number.)
- _____ Regular gifts from family and friends (Please include a statement from family and/or friends of the amount given to you)
- _____ Other. Please explain: _____

Total Source of Income Received: _____

ASSETS:

LIST CURRENT ASSETS OF ALL HOUSEHOLD MEMBERS:

Real Estate: _____ Amount: \$ _____

Individual Retirement Account (IRA, 401K): _____ Amount: \$ _____

Whole life or universal life insurance policy: _____ Amount: \$ _____

() Checking () Savings: Bank: _____ Amount: \$ _____

() Checking () Savings: Bank: _____ Amount: \$ _____

() Checking () Savings: Bank: _____ Amount: \$ _____

Other

Describe: _____ Amount: \$ _____

All applications are subject to the Public Records laws of Florida, SF Chapter 119.

Applicant Statement: The information on this form is to be used to determine maximum income for eligibility. I/we have provided for each person 18 and over acceptable verification of current anticipated annual income. 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 and is punishable by fines and imprisonment provided under S775.082 or 775.83

Applicant

Signature Box:

_____	_____
Applicant's Signature	Date
_____	_____
Co-Applicant's Signature	Date
_____	_____
Household Member 18 or Over	Date



**CITY OF WINTER HAVEN
HOUSING REHABILITATION PROGRAM
UNEMPLOYMENT AFFIDAVIT**

(A separate form is required for any unemployed person over the age of 18, residing in the household)

[1] I, _____, verify that I am presently unemployed and have no other source(s) of income at this time.

OR:

[2] I, _____, verify that I am presently unemployed and have other source(s) of income at this time.

If box 2 is signed please list other sources of income. And provide all official supporting documentation that verifies the sources of the stated income.

SOURCE(S) OF INCOME DERIVED FROM MEANS OTHER THAN EMPLOYMENT

1. _____
2. _____
3. _____

APPLICANT/CO-APPLICANT/ADULT HOUSEHOLD MEMBER SIGNATURE

PRINT NAME

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

Subscribed and sworn before me this _____ day of _____, 20__.

(SEAL)

Notary Public, State of Florida

Print Name of Notary Public

Personally Known

Produced Identification

Type of Identification _____



**CITY OF WINTER HAVEN
 AFFORDABLE HOUSING**

AUTHORIZATION FOR THE RELEASE OF INFORMATION

The undersigned hereby authorizes you to release without liability, information regarding employment, credit, income and/or assets to the City of Winter Haven Housing Program for purposes of verifying information provided as part of the housing assistance.

***Privacy Act Notice:** This information is to be used by the agency collecting it or its assignees in determining whether you qualify as an applicant for the SHIP Program. It will not be disclosed outside the agency except as required and permitted by law. You do not have to provide this information, but if you do not, your application for approval may be delayed or rejected for SHIP Funds.*

INFORMATION COVERED: I/We understand that previous or current information regarding me/us may be needed. Verifications and inquiries that may be requested include, but are not limited to: personal identity: employment, credit, income and assets, criminal history, medical or child care allowances. I/We understand that this authorization cannot be used to obtain any information about me/us that is not pertinent to my/our eligibility for the City of Winter Haven SHIP Program.

GROUPS OR INDIVIDUALS THAT MAY BE ASKED:

The groups or individuals that may be asked to release the above information include, but are not limited to:

Past and Present Employers	Welfare Agencies	Social Security Admin.
Veterans Administration	Banks and Financial Institutions	Credit Reporting Agencies
Unemployment Agencies	Retirement Systems	Background Check
Internal Revenue Service	Public Housing Agencies	Support & Alimony

CONDITIONS:

I/We agree that a photocopy of this Authorization may be used for the purposes stated above. The original of this Authorization is on file and will stay in effect for one year and one month from the date signed. I/We understand that I/We have a right to review this file and correct any information that I/We provided that is incorrect.

_____	_____
Household Member 1 Signature	Date
_____	_____
Household Member 2 Signature	Date
_____	_____
Household Member 3 Signature	Date
_____	_____
Household Member 4 Signature	Date

Notice of Collecting Social Security Numbers:

The County collects your Social Security Number for a number of different purposes. The Florida Public Records Law (specifically Section 119.071 (5), Florida Statutes 2007), requires the City to give you this written statement explaining the purpose and authority for collecting your Social Security Number.

Your Social Security Number is being collected for the purposes of income certification for the City’s Residential Rehabilitation or Down Payment Assistance Program, which requires third-party verification of assets, employment, and income. In addition, this information may be collected to verify unemployment benefits, social security/disability benefits, and other related information necessary to determine income and assets and your eligibility for the program that is funded by local, federal, and/or state program dollars. Your Social Security Number will NOT be used for any other intended purpose other than verifying your eligibility for the City’s program.

Certification and Waiver of Privacy:

The applicant(s) certifies that all information in this application and all information furnished in support of this application, is given for the purpose of obtaining funding under the City of Winter Haven Residential Rehabilitation or Down Payment Assistance Program.

I/we understand that Florida Statute 817 provides that willful false statements or misrepresentations concerning income, asset, or liability information relating to financial condition is a misdemeanor of the first degree, punishable by fines and imprisonment provided under Florida Statutes 775.082 and 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. I/we hereby waive my/our rights under the privacy and confidentiality provision act, and give my/our consent to the City of Winter Haven Residential Rehabilitation or Down Payment Assistance Program, its agents, and contractors to examine any confidential information given herein. I/we further grant permission and authorize any bank, employer, or public or private agency to disclose information deemed necessary to complete this application.

_____	_____	_____
Signature of Applicant	Printed Name of Applicant	Date

_____	_____	_____
Signature of Applicant	Printed Name of Applicant	Date

_____	_____	_____
Signature of Applicant	Printed Name of Applicant	Date

